Maternal and Child Health Services
Title V Block Grant

State Narrative for New Mexico

Application for 2010
Annual Report for 2008

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I. General Requirements

A. Letter of Transmittal

The Letter of Transmittal is to be provided as an attachment to this section.
An attachment is included in this section.

B. Face Sheet

The Face Sheet (Form SF424) is submitted when it is submitted electronically in HRSA EHB. No hard copy is sent.

C. Assurances and Certifications

The central office of the New Mexico Title V MCH Program maintains a reference copy on file in the State MCH program's central office and will be made available upon request. If you would like to request copies, please call the Family Health Bureau Chief at 505-476-8901

D. Table of Contents

This report follows the outline of the Table of Contents provided in the "GUIDANCE AND FORMS FOR THE TITLE V APPLICATION/ANNUAL REPORT," OMB NO: 0915-0172; published March 2009; expires March 31, 2012.

E. Public Input

Upon receiving final Block Grant approval from the Maternal Child Health Bureau of the Health Resources and Services Administration, the NM Department of Health will publish a notice in the Albuquerque Journal, which has statewide distribution, inviting the public to comment on the current Title V Block Grant.

The Title V Block Grant will be available to the public for review at each of the four regional offices of the Public Health Division located in Santa Fe, Albuquerque, Las Cruces and Roswell, as well as the Title V State Office in Santa Fe. /2008/A bound copy of the report will also be placed in the State Library. //2008// The Title V State Director will consider public comments on the Block Grant for a specified period of thirty days. The Title V State Office will acknowledge comments, and the Family Health Bureau Management Team will review summary of comments and follow up on critical issues. Comments will be considered by the FHB Management Team when evaluating program services and developing the subsequent year's Block Grant.

The MCH Block Grant Application is distributed to Public Health Division local health offices as a resource for their use in planning efforts for local areas. The performance measures are aligned with the DOH Strategic Plan. The reports to the legislature and its interim committees are based on the information compiled in the grant proposal.
Children's Medical Services' (CMS) Family partners including Parents Reaching Out (PRO), Family Voices, Parents of Behaviorally Different Children, and the MCH Collaborative are working closely with CMS to learn about and provide input in the grant and the DOH Strategic Plan. This will be an ongoing effort between CMS and its partners.

/2009/An interactive web page was created on the Department of Health public web site. The site includes links to the Title V grant report and application, and to the 2005 Needs assessment. Through the site, the public is able to access the "public input" link to provide comments. The URL is: http://www.health.state.nm.us/TitleV. A separate email address for New Mexico Title V reporting was created to receive public input, and to provide a central location for the exchange of Title V information. A week-long ad was placed in the Albuquerque Journal inviting the public to

comment on the 2006 report/2008 application:

"You are invited to comment on the current Title V Maternal and Child Health Block Grant 2006 report/2008 application. The grant is available for review at each of the Public Health Division regional offices in Santa Fe, Albuquerque, Las Cruces and Roswell, at the Title V State Office in Santa Fe, at the main state library in Santa Fe, and online at: http://www.health.state.nm.us/TitleV and
https://perfdata.hrsa.gov/mchb/mchreports/Search/search.asp

Comments on the report/application are accepted throughout the year. Send them to: Title V Epidemiologist, NM Department of Health, Family Health Bureau, 2040 S. Pacheco St, Santa Fe, NM 87505. You may also send comments or questions at any time by email to NM.TitleV@state.nm.us. For comments to be considered in the 2007 report/2009 application, they must be received by May 30th, 2008."//2009//

/2010/The Maternal and Child Health programs of the Family Health Bureau solicit and receive public input on an ongoing basis as a regular part of their meetings with stakeholders and community partners. The following is a list of organizations and meetings that that include participation from the public:

ECAN (Early Childhood Action Network) Steering Committee (monthly meetings)
Multi-Agency Team Meeting (Young Child Wellness Council) Local & State Level (monthly meetings)
FLAN (Family Leadership Action Network) Planning Council and Annual Meeting
Certified Nurse Midwives Advisory Board (quarterly meetings)
Licensed Midwives Advisory Board (quarterly meetings)
Santa Fe County Home Visiting Collaborative (quarterly meetings)
Home Visiting Task Force (State level) (quarterly meetings)
EPSDT (Early Periodic Screening Diagnostics and Treatment) Meetings (quarterly meeting)
DSI (Developmental Screening Initiative) New Mexico Stakeholder's Update Meeting
Project LAUNCH (Linking Actions for Unmet Needs in Children's Health) (monthly conference call)
Turn the Curve Planning Meetings for ECCS (Early Childhood Comprehensive Systems) Grant and Annual Meeting
House Joint Memorial 60 Task Force Meetings (Monthly Meetings)
Title V MCH Block Grant Needs Assessment Regional Meetings
Families FIRST Annual Meeting
Public Health Division Prenatal Care Planning Meetings and Annual Meeting
Project LAUNCH Grantee Meetings (twice yearly)
ECCS Grantee Meeting (yearly)
Maternal Depression Work Group (monthly meetings)
Obstetric Liability Insurance Meetings (as needed)
Healthy Weight Council Meetings (3 times per year)
Santa Fe County Maternal Child Health Council (quarterly meetings)

Children's Medical Services (CMS) receives public input in several ways: through the MCH Collaborative a monthly meeting between CMS, Family Voices, PRO and EPICS; through the Title V needs assessment; through the advisory councils for the Genetic Screening program, the Newborn Hearing Screening program and for the CYSHCN program. These advisory councils include representation from various stakeholders including professionals, families, and other agencies. The Asthma Summit that was held throughout the state in 2007-2008 was a successful mechanism for receiving public input. The CMS Social Workers in the field also participate on community councils and receive input from the public on various local maternal and child health issues.//2010//

II. Needs Assessment

In application year 2010, it is recommended that only Section IIC be provided outlining updates to the Needs Assessment if any updates occurred.

C. Needs Assessment Summary

Since submission of the Title V MCH Block Grant in July 2006, including the Comprehensive Assessment in 2006, there were no differences in the State's priority needs and no changes in needs assessment processes. Partnership building and collaboration in selection of the state priority needs was an ongoing process.

The selection of the state performance measures are an indication of the Title V MCH priorities:

1. The number of NM counties and tribal entities that are implementing positive youth development strategies as defined by 6 criteria

2. The percent of first newborns and mothers who receive home-visiting programs

3. Reduce unintended pregnancy to less than 30% of births with the focus on teens.

4. Reduce the number of children witnessing violence

5. Increase the proportion of women who report having all six criteria of the NM Healthy Birth Index

6. Reduce the proportion of women who report being physically abused by a husband or partner during pregnancy

7. (State Performance Measure #8) Increase the proportion of women who deliver a live infant who are reported to have been screened for syphilis during pregnancy. Note: This SPM is new, replacing SPM 07 that aimed to reduce the proportion of children overweight/at risk of overweight. National Performance Measure 14 addresses the issue of childhood overweight and obesity.

There were changes in the State capacity to meet the needs since last Block Grant Application due to cuts in the budget for period Oct 2005-September 2006. The impacts of the $250,000 cut were reduced youth development activity, reduced services by the Medical Director, and reduced services to: high risk prenatal care clients, family planning clients, and children with special health care needs.

WIC

Using SSDI funds, data on WIC children at risk of overweight and obesity is being produced with linkage to birth files. These funds were also used to build case management data applications for the Families FIRST program.

Families FIRST

Families FIRST is a case management program that serves Medicaid eligibles age 0-3 years and pregnant women. This statewide program needs to be able to evaluate these dimensions of its services to clients: 1) A description of clients including socio-demographic & health characteristics, 2) the type of risks that are addressed by the program, 3) the result of program services such as referrals, and 4) selected program outcomes. The new database is not adequate for these information needs. Funded by SSDI, MCH epidemiologists have consulted with Families FIRST staff to develop the framework and select variables for the new database. In

addition, the program seeks to electronically link birth+infant death files as well as Medicaid files. Such linkages will greatly enhance analysis of the program's characteristics, services and outcomes.

PRAMS
NM PRAMS reports on preconception health, an emerging issue related to the need to improve key indicators of maternal and infant health including low birth weight, infant mortality, birth defects and barriers to optimal parenting. Only 6.2% of mothers who had a live birth in period 1998-2003 had none of the critical preconception risks. These data were presented to the Public Health Division Leadership Team in spring 2006; they were incorporated into the PHD's proposal for funding expansion for the years 2007 and 2008. The preconception index was released in Oregon at the Title V MCH Leadership Institute. Border health and teen pregnancy are two other emerging issues in the PRAMS data.

NM PRAMS, special reports to Border and Navajo:
In April, 2006 PRAMS/MCH EPI Staff met in Shiprock, NM, with Navajo Nation area health agency staff. PRAMS staff presented an overview of the surveillance methodology and data currently available. The group continues to collaborate to produce PRAMS Navajo Nation surveillance reports and presentations. The group also discussed the desirability of increasing participation rates among Navajo women for the PRAMS survey.

The Early Childhood Action Network (ECAN) promoted the use of data for action in a meeting that included participation by the Lt. Governor of NM, key state senators and representatives, department secretaries, and public and private sector representatives from programs that serve young children. MCH Epidemiology provided data for the report card that was developed by ECAN contractors. The purpose of the workshop was to ask participants to determine what it would take to "turn the curve" on the trend line for data in the report card. The top priorities for action that could help to "turn the curve" were home visiting services for the 0-3 population; and strategies to address the NM Healthy Birth Index. Details of ECAN activities, data focus, and copies of reports can be found at: www.earlychildhoodnm.com. Five sets of indicators were developed:

New Mexico's Young Children will be 1) Healthy, 2) Safe, 3) Educated, 4) Supported, and 5) Involved in their Communities. A second turning the curve meeting was held in April, 2007, and new policy initiatives were developed using Title V data.

Children's Medical Services and Children and Youth with Special Health Care Needs (CMS/CYSHCN)
During 2006 there was a drop in the percentage of CYSHCN receiving flu shots from 82% to 66%. This was true only for families with with an English-speaking adult. Families with no English-speaking adult maintained flu shots for CYSHCN at 82%. CMS and FHB are investigating the reason for this and developing an intervention strategy.

//2009//Children's Medical Services has conducted Asthma Summits in four of New Mexico's five regions. The asthma summits are part of the 2010 Needs Assessment and provide information about the health of New Mexico's children including health care access, trends in clinical care, and environmental factors.

A GSIP fellow is working with Children's Medical Services and MCH Epidemiology to assess the data capacity and needs of the CMS program.

Maternal Health program is completing an assessment of capacity and needs for prenatal care and obstetric services by county.//2009//

/2010/Two regional needs assessment meetings were held in 2008. The meetings took

place in Albuquerque (region 3) and Roswell (region 4). Fifteen people attended the region 4 meeting, and 20 attended the region 3 meeting. Participants represented state government, county health councils, private sector service providers, non-profit organizations, and school health. FHB staff facilitated focus groups on each of the 10 priority areas that had been identified in the 2005 Needs Assessment. Participants discussed their capacity and needs in each of these areas, and were also given the opportunity to identify and discuss additional priorities. Activities for summer of 2009 include visiting the remaining 3 regions to solicit input, identifying priorities, creating and disseminating an online survey, and conducting Q-Sort activities in each region. The Needs Assessment leaders are working to include input from a broader range of stakeholders. A HRSA GSIP intern is assisting the Needs Assessment coordinator during the summer.//2010//

III. State Overview

A. Overview

PRINCIPAL CHARACTERISTICS AND THE HEALTH NEEDS OF NEW MEXICO'S MCH POPULATION

New Mexico was the 20th fastest growing state between 2000-2003. In 2003 NM ranked sixth lowest in population density at 15.4 persons per square mile and fifth in size at 121,365 square miles. The total population was estimated at 1,874,614 persons, a 3.1% increase since 2000 and 0.64% of the total U.S. population. NM remains a young state with 30% of the population under age 20, compared to 28.1% for the U.S; an estimated 12% was over age 65, compared to 12.3% for the U.S. NM Population Density, 2003: There are 33 counties in the state to which reference will be made throughout this document. The map shown here depicts population density: only 8 of the 33 counties had a density greater than 14.2 persons per square mile. The state has borders with Arizona to the west including a common territory with the large Navajo Nation in the northwest corner; Colorado to the north; Texas to the east and the southern edge to the hook on Dona Ana County; and a common border with Mexico in the southwestern corner. NM became a "minority majority" state in 2000, with the combined Hispanic, Native American, Asian and African American population being greater than non-Hispanic Whites. There were significant differences in many health and social indicators between racial and ethnic groups; the NM Department of Health (DOH) has made significant strides in assuring that policies and programs be culturally competent. According to 2003 population estimates, 85.6% of New Mexicans were white (includes individuals of Hispanic origin), 2.5% were Black, 10.3% were American Indian and 1.55 were Asian or Pacific Islander. Hispanics made up 43.2% of the population; non-Hispanics 56.8%. An estimated 67% of N.M. children and 55% of adults were of a minority group. Nearly 55% of the state's children were Hispanic, the highest proportion of any state. In 2003 the racial distribution of children is shown below; a greater proportion of the 0-2 year old population was of minority group than subsequent age sets; The majority of white children were Hispanic.

Among females 67% of the population was of a minority group. Lower proportions in higher age groups among Black and American Indian suggests higher mortality rates in these two populations. Source: NM Intercensal Estimate, BBER/UNM 2003 An estimated 20% of NM children were born of immigrant parents. Sources other than the National Survey of Children's Health (NSCH) document that the majority of NM immigrants are of Hispanic origin. Source: National Survey of Children's Health, 2003; Analysis by MCH Epi NM, Stata v.7 NATIVITY AND LANGUAGE: Ten percent of the people living in NM in 2003 were foreign born. Ninety percent were native, including 56 percent who were born in NM. Among people at least five years old living in NM in 2003, 36 percent spoke a language other than English at home. Of those speaking a language other than English at home, 78 percent spoke Spanish and 22 percent spoke some other language; 31 percent reported that they did not speak English "very well." American Community Survey, US Census, 2003 www.census.gov/acs.

Children of immigrants are the fasted growing part of the U.S. population. Most live in mixed status families. Legal and undocumented parents may be reluctant to approach publicly funded services despite their child's eligibility based on birth. Many of these children live in families with low incomes, have parents with low education level and limited English proficiency, and interact less often with their parents. These factors may be associated with poor school performance by the children. Young children of immigrants are substantially more likely to be poor and to experience food and house related hardship --56% as compared to 40% of young children of natives. Children of immigrants are more likely to have fair or poor health and to lack health insurance or a usual source of care. Children of immigrants are more often in parental care and less often in center-based care. Yet center-based child care may benefit a child's early development (The Health and Well Being of Young Children of Immigrants by Randy Capps, Michael Fix, Jason Ost, Jane-Reardon-Anderson and Jeffrey S. Passel, Urban Institute, 2004; report available at www.urban.org.)

SOCIO-DEMOGRAPHICS AFFECTING MCH WELL-BEING: Family structure is associated with child health, while cultural variations such as extended families or the ways in which social networks support children and parenting are not reflected in official statistics. US Census 2000 data for NM reported that 63% of NM children lived in two-parent households; an estimated 8% of children lived in single father families; an estimated 22% of children lived in single mother families; and 6% of children were reported to live with grandparents or other relatives. In 2003, 48.5% of NM births were to single mothers, more than doubling from the 1982 figure of 22.1%; and greater than the estimated 34% for the nation in 2002. Significant differences were reported between racial-ethnic groups and age groups. Between 2002-2003 the marriage rate decreased from 7.9 to 6.9 marriages per 1,000 population and the divorce rate decreased from 4.4 to 3.4 divorces per 1,000 population. Both rates were lower than U.S. rates.

The Burdens of Poverty: In 2003, NM ranked 46th in per capita personal income at $25,502, which was 81.1% of the national average. The state's poverty rate remains one of the highest in the nation. In 2003 an estimated 18.6% of the NM population lived below 100% of the federal poverty level (FPL) compared to 12.7% of the US population. Significant disparities were reported for racial-ethnic groups: 31.6% for Blacks; 30.6% for Native Americans; 24% for people of Hispanic origin; and 16.4% for Whites. For many years NM has ranked among the four worst states for the proportion of children living £100% FPL and of low income children £200% FPL. In 2000, an estimated 11% or 57,000 of the state's children lived in deep poverty, at or below 50% of the FPL. To place these data in perspective, a family of 3 persons with an income of $15,670 was <100% FPL. In 2002, the percent of children living at or below poverty varied from 44.3% in McKinley County to 2.6% in Los Alamos County. All but 11/33 of the counties reported a higher rate of childhood poverty than the state average of 25.2.

In 2003 an estimated 24.5% of NM's children lived in poverty compared to 17.8% in the U.S. The NM percent of near-poor families below 200% of poverty was 1.3 times that of the U.S. By contrast, the US had a higher proportion of higher income families than NM.
Source: Child and Adolescent Health Measurement Initiative (2005). National Survey of Source: Children's Health, Data Resource Center on Source: Child & Adolescent Health website. Retrieved June 2005 from www.nschdata.org.

Title V MCH programs and its MCH partners strive to address the high rate of poverty in the state and the disproportionate burden of coping with less social advantage, particularly among minority groups who make up, the majority of this population. Gaps and disparities are seen consistently among teens, parents with only a high school education or less, and single parents. These characteristics translate into greater proportions of health risk behaviors, and lower access to and use of primary preventive care or specialty care. Although the state has made progress in reducing the proportion of the population that has no health insurance, critical gaps persist. There is a significant challenge in assuring access to care for the working poor and immigrant families who come into the state --many who pay taxes on their income.

There were significant disparities within 2003 poverty data that have implications for MCH policies and programs. Comparing NM to the US, the proportion of these segments of the population lived at or below 100% FPL (www.statehealthfacts.kff.org),: v 27% of NM adults with children v. 19% for the US v 23% of NM females v. 18% of NM males; 16% of US females v. 14% of US males v 20% of people living in NM metropolitan areas; 28% in non-metropolitan areas. EDUCATION: In 2003, NM ranked 46th of 50 states in high school graduation rates. In 2003, 80 percent of people 25 years and over had at least graduated from high school and 24 percent had a bachelor's degree or higher. Nearly 20% of the population had less than a 12th grade education; 27.39% were high school graduates. The three key dimensions of health: health outcomes, health behaviors and access to/use of health services are all related to educational levels in NM. Among people 16 to 19 years old, 10 percent were dropouts; they were not enrolled in school and had not graduated from high school. The total school enrollment in NM was 515,000 in 2003. Preprimary school enrollment was 55,000 and elementary or high school enrollment was 338,000

children. College enrollment was 122,000. American Community Survey, US Census, 2003 www.census.gov/acs.

Employment: Unemployment is a critical issue for NM. In 2000, the NM unemployment rate was 4.8%; and in 2005 it was 6%. In 2003, an estimated 70% of NM households had at least one full-time worker v. 73% in the US; 9% were part-time in NM v. 7% in the US; and 21% were households with no employed persons in NM v. 19% in the US. The impact of unemployment on families and children is significant, not only for the stark experience of being unemployed but also for the emotional stress it places on parents.
Use of Welfare to Work Program and the Food Stamp Program: While over 24% of families with children lived =100% FPL, less than ¼ of poverty level households had a member who actually used the TANF or cash assistance programs: Source: National Survey of Children's Health, 2003; Analysis by MCH Epidemiology (Epi) NM, Stata v.7 In NM in June 2004 there were 17,000 cases comprising 43,736 individuals, 16,029 adults and 27,624 children in the Temporary Assistance to Needy Families (TANF) program. Participants must be needy by state eligibility ($12,732/year for family of 3); and must participate in work activities after 24 months (they can attend school up to 24 months). Expenditures totaled $5.3 million that was a -¬0.5% decrease from the previous year. While NM families and pregnant women have relatively high rates of food insecurity compared to the nation, just over 1/2 of poverty level households had a member who actually used the food stamp program.
Source: National Survey of Children's Health, 2003; Analysis by MCH Epi NM, Stata v.7 In June 2004 there were 88,499 cases, 48.4% were adults and 51.6% were children; the majority or 58.4% were Hispanic followed by 24.7% White, 13.6% Native American. Geographic Distribution of the Population: There are 33 counties in NM: 14 are frontier or sparsely populated having only 8% of the population; 9 are rural areas with 34% of the population; 3 are urban areas with 11% of the population (Los Alamos, Sandoval and Valencia); and 3 are metropolitan areas with close to half of the population (Bernalillo county with Albuquerque, Santa Fe and Dona Ana with Las Cruces). This population distribution is characteristic of the large, mountainous states in the Rocky Mountain West, and presents unique challenges to provision of primary preventive care and specialty care.

Issues of Access to Health Care: Many counties of NM have gaps in critical services for primary care, dental care and mental health care. Using 2002 federal designations of Health Professional Shortage Areas (HPSA), 28 of 33 counties were HPSA for primary care; all but nine for dental care; and all but four for mental health care. In 2004, new definitions were introduced making comparisons somewhat difficult. Large proportions of the state remained HPSA qualified in all three categories. Detailed maps were published in 2005 by the NM Health Policy Commission and are found at www.hpc.state.nm.us. Specialty services are found primarily in the Albuquerque area, the location of the only two perinatal specialty hospitals in the state; one specialty hospital for children and youth with special health care needs (CYSHCN); and the majority of specialists in the state.

HEALTH CARE WORKFORCE ISSUES From a summary prepared by the NM Health Policy Commission, three major factors contribute to the workforce environment: high poverty levels, a largely government based economy and demographic changes. The latter refers to the out-migration of people with college degrees and in-migration of those with less than high school education. The following issues as well as outside competition affect the retention of health professionals: v low reimbursement rates by Medicaid and Medicare coupled with high levels of Medicaid and Medicare enrollment v poor work environment, especially in frontier and rural sites v large rural stretches and rural areas that do not have socio-cultural amenities for a family v minimal professional interaction --in rural and frontier areas. Out of 4,231 physicians in NM the 2000 racial ethnic distribution of licensed physicians was out of sync with the population's racial-ethnic distribution. Only 7% were Hispanic while an estimated 50% of NM children were Hispanic; and 0.4% were Native American while ~13% of children are Native American. Finally, an estimated 60% were white, non Hispanic, 1.1% were African American, 4.7% Asian American and the rest were unknown. Several initiatives were in place in 2004-05 to recruit and retain

health care professionals for NM. These include the J-1 Visa Waiver Program; the NM Health Service Corps; a Specialty Extension Services program, Locum Tenens, Health Loan-for-Service, Loan repayment program, and the Western Interstate Commission on Higher Education (WICHE) and Baylor Dentistry Programs. The above section was abstracted from the NM QuickFacts, the annual reports of the NM Health Policy Commission: www.hpc.state.nm.us.

HEALTH INSURANCE COVERAGE IN NM: In 2003, an estimated 414,000 New Mexicans (22%) did not have health insurance; 70 percent of the uninsured were working people; and only 50 percent of small employers (under 50 employees) offered employer sponsored insurance plans. The NM Health Policy Commission, 2005 Quick Facts, summarized key issues that characterize health insurance coverage: In 2003, v 48.9% of New Mexicans had insurance coverage through an employer compared to 60.4% nationally. v 19.3% of New Mexicans were covered by Medicaid and 15% by Medicare, compared to 12.4% Medicaid and 13.7% Medicare in the United States. v Military coverage insured 4.8% of New Mexicans compared to 3.5% nationally. v Using a three-year average, NM had the second highest proportion (21.3%) of uninsured population in the nation (Texas had 24.6% and the best performer, Minnesota had only 8.2% uninsured). v In 2004 the state's uninsured population nearly matched the number of Medicaid enrollees: 414,000 uninsured and 420,145 on Medicaid. NM ranked among the worst five states for the highest proportion of children living at or below the federal poverty level (FPL) for many years. Thus it is no surprise to see that there are 1.4 times as many NM children at or below 200% of poverty than in the nation. On the other hand, while poverty levels remained high in NM, the proportion of uninsured children decreased about 50% from 15.1% in period 1999-2001 to 7.5% in 2001-2003. In real numbers, in the five year period of time, an estimated 27,000 fewer children were uninsured (81,000 in 1999-2001 period to 54,000 in the 2001-2003 period). The Medicaid reports of June 2001-2004 indicated an average annual percent increase in children enrolled of 6.6%. In June 2001 there were 223,290 children enrolled; in June 2003 the number was 260,500; an increase of 37,000 children. (Monthly Statistical Reports, NM HSD).

In 2003, the National Survey of Children's Health (NSCH) that found 9.6% or 48,134 NM children age 0-17 had no insurance as compared to 8.8% of US children.

While the proportion of low-income and very poor children <200% of poverty in NM has not changed in over 10 years, it does appear that fewer of these children are uninsured --and hence, have access to health care.
The NSCH reported key differences in having any form of health insurance. While the NSCH does not provide more localized data --such as by county or public health district --it does describe disparities in coverage by age group.

Percent of Children with Any Form of Health Insurance, by Age Groups, NM 2003, from National Survey of Children's Health

Age Child	No	Yes	Don't Know
0-2 years	10.8%	89.2%	0.0%
3-5 years	6.1%	93.9%	0.0%
6-9 years	9.8%	90.2%	0.0%
10-13 years	11.1%	88.4%	0.5%
14-17 years	9.5%	90.5%	0.0%
All children 0-17 years	9.6%	90.3%	0.1%

Disparities in coverage by race and ethnicity, and uninsured included
v 7% or 11,300 White children
v 10.2% or 25,330 Hispanic children, a rate that was 1.4 times White children
v 12.2% or 983 Black children
v 14.5% or 9,000 Other children -in the NM sample of the NSCH this group included Native Americans. The rate was 2.1 times that for White Children. It would seem that Native American respondents in this group --all of whom are eligible for Indian Health Services --did not consider I.H.S. to be a form of coverage in this survey.

Nearly half of NM children were covered by Medicaid or the state Children's Health Insurance Program (S-CHIP). An estimated 46.9% of all children were covered by Medicaid or the state child health insurance program (S-CHIP); and 52.4% had some other forms of coverage (health insurance, pre-paid plans such as HMOs).
An estimated 16.9% of NM children age 0-17 were currently uninsured or not covered for some period of time in past year compared to the US figure of 14.9%.
Of NM children who had current coverage, 7.96% reported gaps in coverage. An additional 9.6% had no coverage at all. This figure approximates the national report of NM data (16.9%).
Those whose coverage was Medicaid had 2.24 times the risk of not being covered at some time in the past year compared to those with other forms of coverage (RR 2.24,). This data was collected in 2003, before Medicaid instituted rules that required re-certification for eligibility every six months. It is thought that the risk of gaps increased during 2004-05.

Disparities in insurance in NM for 2003 were reported in the NSCH 2003; more analysis is needed to understand these data and their implications for policy or program initiatives:
Children of parents not born in the US, and children not born in the US were more likely to not have current health insurance in 2003. See section on immigrant health.
Between 11-14% of NM children age 0-17 were potentially eligible for Medicaid (<185% FPL) or S¬CHIP (185-235% FPL) and were not covered by any form of health insurance.
It appears that child health insurance coverage has improved and may still be improving as this report goes to press. Some of the key issues regarding health insurance coverage are known to persist (abstracted from Who's Uninsured in NM and Why? www.familiesusa.org) and from qualitative information gleaned during the needs assessment exercise): Employer-based coverage for those who work in small businesses continues to be unaffordable for the business or the employee. About 23% of New Mexicans worked for small employers in 2000. v Service and labor jobs are less likely to provide insurance; about 63% of uninsured workers hold such jobs, although they make up only 40% of the workforce. v Part-time workers are often not eligible, thus their children are affected. v Low wage workers are often not able to afford health insurance offered by the employer. v People who lose their jobs often lose health insurance; the unemployment rate in NM went from 4.8% in 1999 to over 6% in April 2005. v People --including children-with any pre-existing condition have to pay significantly more for private insurance or may not be able to afford it at all. v Keeping current is a challenge --families who lost work or have decline in income may not be aware they qualify for Medicaid or S-CHIP. v The present 2005 policy to require re-certification every 6 months may begin to show up in the data as a gap in coverage, or no coverage for those who may be discouraged by the paperwork involved. v Immigration status imposes a 5-year delay from time of legal entry to the US for children to apply for Medicaid or S-CHIP. Citizen children living in immigrant families are eligible for Medicaid/S-CHIP but may not enroll because of parents' language barriers, confusion about eligibility and program rules and fear of repercussions for using public benefits (cited in Future of Children 2003 as well as direct observation by NM public health staff) v Language barriers cause confusion about eligibility and program rules and in the case of immigrants fear of repercussions for using public benefits v The increasing cost of medical care and hospitalization is a risk because it discourages providers from accepting Medicaid children and families.

Finally, the NSCH reported on the percent of children who had coverage for dental care. The proportion who had some coverage for dental care is less than the proportion of children who had some form of health insurance. There are real gaps in access. There are still too few dentists who accept Medicaid, and children in smaller communities may have to travel over 100 miles to reach a dentist.

Medicaid and the State Child Health Insurance Program (S-CHIP) A report on Medicaid by the NM Health Policy Commission, 2005 Quick Facts, summarized key issues impacting NM Medicaid: "The 2004 state legislature required Medicaid to reduce spending by $40 million beginning on July 1, 2004 in order to stay within the $475 million budget (state share) set by the legislature. On July 1, 2004, NM Medicaid implemented a cost containment program that is

expected to save an estimated $6 million by reducing provider reimbursements by 1.5%. Physicians, practitioners and other service providers were affected including, hospice, waiver services, treatment foster care providers, dental services, case management, early intervention, Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) screening, inpatient hospital services (in-state general acute hospitals and border area hospitals), outpatient hospital services such as laboratory services; dialysis services; and ambulatory surgical centers (Notice of Reduction in Medicaid Payments www.state.nm.us/HSD. On July 1, 2004, NM Medicaid implemented changes in client eligibility certification. Children's Medicaid eligibility periods changed from one year to six months ***/2010/ Eligibility for children changed from six month recertification to one year recertification in 2008.//2010//***and pregnancy and family planning eligibility changed from two years to one year. A cost sharing initiative is in process and expected to be implemented in 2005 as recommended by the Medicaid Reform Committee and required by legislation passed in the 2003 Legislative Session. As of July 2004, the NM Human Services Department reported 420,145 New Mexican enrollees in Medicaid, about 22.41% of the state population. 268,734 (63.96%) of enrollees are children. The Federal Matching Rate for NM Medicaid has decreased from 78% in Fiscal Year 2004 to 74% in FY 2005. In FY 2004, the federal government paid 77.8 cents of every dollar spent on the basic Medicaid program in NM; in FY 2004, 74.3 cents. Over 15,500 providers participate in the Medicaid program in NM. Although the number of children under 21 years of age enrolled in Medicaid has steadily increased since 2002, children as a percentage of the total enrollment in Medicaid has decreased from 66.47% in 2002 to 63.96% in 2003."

NM has 34 eligibility categories that include individuals receiving Supplemental Security Income (SSI); families in the Temporary Assistance to Needy Families (TANF) program; poverty level women and children; and persons residing in long term care facilities. Pregnant women and children £185% FPL are eligible for Medicaid; children between 185%-200% are eligible for S-CHIP; women £185% FPL are eligible for the 1115 Medicaid waiver for family planning services. Other eligibility criteria are found in the Needs Assessment attachment. NM eligibility criteria do not follow the usual published figures for the population by Federal Poverty Levels.

INDIAN HEALTH: POPULATION, HEALTH SERVICES AND TRIBAL HEALTH ENTITIES An estimated 12.3% of the 2003 NM population were members of 22 tribal entities (although note that not all tribal members reside within a federal tribal area: v Apache at Jicarilla in the North East and Mescalero in the South Central part of the state v Navajo in the NW corridor along the NM --Arizona border v Eight Northern Pueblos--Nambe, Picuris, Pojoaque, San Ildefonso, San Juan, Santa Clara, Taos and Tesuque v Eleven central area Pueblos -Acoma, Isleta, Jemez, Laguna, San Felipe, Sandia, Santa Ana, Santo Domingo, Ysleta Del Sur, Zia and Zuni Health care for tribal members is available through Navajo Area Indian Health Service (I.H.S.) with units at Gallup, Crownpoint and Shiprock; the Albuquerque Area I.H.S. with units at Albuquerque and Santa Fe. Hospital discharge data for NM does not include I.H.S. or tribal hospitals. Tribal WIC programs are organized to serve the Eight Northern Pueblos, Isleta, Zuni, Five Sandoval, Santo Domingo, San Felipe and Acoma-Canoncito-Laguna areas. Note that NM WIC program data includes Mescalero, Alamo, Jicarilla Apache and First Nations in Albuquerque but not the other large tribal WIC entities. Population-based information about WIC clients is produced by NM Pregnancy Risk Assessment Monitoring System for mothers and infants up to age 9 weeks. There are several initiatives of collaboration between the DOH and tribal or I.H.S. that serve to assure Native American needs are incorporated into the state public health community: v The Native American Data Advisory Working Group (NADAWG) that began about 5 years ago and has been formalized with a staff person in the Epidemiology & Response Division (ERD) of the NM DOH. This group strives to share public health data projects --surveillance, monitoring, evaluation, research --as a form of data to action, and collaborative sharing.

v The County Health Council initiative includes four tribal councils: ToHa'jiilee within Navajo territory; and Acoma, Cochiti and San Ildefonso pueblos.

v NM Vital Records and Health Statistics produces a Tribal Report of birth and death data --the most recent edition covered 1995-1997. This report is available at www.health.state.nm.us.

HEALTH CARE COVERAGE AND ELEMENTS OF THE NM SAFETY NET Some of the NM population has no health insurance coverage for a variety of reasons including but not limited to immigrant status and employment without insurance coverage. The safety net for direct health services is comprised of the following:
v County Indigent Funds: each county has specific critieria for eligibility; in the 2005 needs assessment, county level public health professionals cited the difficulties for families who may move from one county to another.
v State General Fund, Healthier Kids Fund: this fund, $800,000 in 2004, is administered by Children's Medical Services (CMS) and purchases services for primary care needs of children who have no possible source of coverage.
v Title V MCH Block Grant, Children's Medical Services (CMS): funds are used to procure high risk insurance for children who have no coverage, and who have serious conditions requiring specialty care.
v Title V MCH Block Grant, High Risk Prenatal Fund: funds are used directly and cover prenatal and delivery costs for women at high risk and have no possible source of coverage.
v NM Department of Health, MCH Services in Local Health Offices: selected MCH services are offered in areas where there are no prenatal or well child providers; case management for children with special health care needs and family planning clinical services are offered in every county; registration does not include residential status, and DOH policy forbids denial of service based on race, ethnicity, age, sexual orientation or other potential reasons for a person to feel marginalized or the object of discrimination.
v MCH Services in Federally Qualified Health Centers and Community Health Centers: limited MCH services, particularly prenatal care, is offered due to provider preferences and training and costs of malpractice insurance.

COUNTY HEALTH COUNCIL PRIORITIES IN 2005
In 2005, each of the 33 counties of NM had a County Health Council (CHC); four of them were newly created in working on council development including needs assessment and setting priorities. There are four Tribal Health Councils at Acoma, ToHa'jiliiee, Cochiti and San Ildefonso. They included Harding and Union in the northeastern corner and Lea and Roosevelt in the southeastern corner of the state. While many counties had core funding from the County MCH Act and its state general fund mechanism, additional funding streams were added. A more detailed analysis of the CHC and Tribal Health Council Plans will be done in 2005-06 to examine the degree to which strategies and interventions actually target the MCH population. There is high potential for the CHCs to contribute to progress in key MCH outcomes and the health and wellbeing of the 0-3 year old population. Counties with core MCH priorities included the following Counties with more general DOH Priorities included the following Breastfeeding = 1 (Colfax)Family strength = 2 (Grant and Torrance)Home visiting = 1 (Santa Fe) Immunizations = 1 (Colfax)Low birthweight = 2 (Colfax and Rio Arriba)Teen Pregnancy = 17 of 33 counties Violence-Abuse = 7 counties Youth violence and crime = 3 (Eddy, Los Alamos and Taos) Access to continuum of care = 9 of 33 counties Behavioral Mental Health = 3 (Cibola, Colfax, Rio Arriba)Diabetes = 1 (Colfax) and 4 tribal health councils Obesity = 10/33 counties Economic Development = 2 (Grant and Hidalgo)Heart disease = 1 (Hidalgo)Suicide = 3 (Cibola, Colfax and Rio Arriba)Substance Abuse = 19 of 33 counties and 2/4 tribal councils Transportation = 1 (Sierra). The United Health Foundation report revealed that NM ranked at 50th or 49th for four out of nine indicators. The report stated that until the issues of poverty and education are improved, the work of the state's safety net will continue unabated. While dollars are stretched, the state had relatively poor performance for its investments in support for public health care. www.unitedhealthfoundation.org.
Similarly, the Kids Count report for 2004 placed NM 48th in the nation, largely for performance on poverty related issues: percent of families headed by single parent (NM 32%, US 27%); children in poverty (NM 32%, US 21%); children living in families where no parent has full-time, year-round employment (NM 38%, US 28%); teens age 16-19 not attending school and not working (NM 14%, US 9%); teens 16-19 who are high school drop outs (NM 14%, US 10%); teen age 15-19 death rate for accident, homicide and suicide (NM 92/100,000 and US 60/100,000); and teen

age 15-19 birth rate (NM 46/1,000 and US 33/1,000). NM compared somewhat favorably to the US for low birth weight babies (NM 7.5%, US 7.4%); infant mortality (NM 6.2/1,000 live births, US 7.3/1,000 live births).

Because of a younger age structure than the nation, the State's crude death rate was lower than the nation: for 2003 the rate in NM was 806.7 compared to a US rate of 845.3. Leading causes were heart disease, malignant neoplasms and unintentional injury. Leading causes among children 1-14 were unintentional injuries, congenital malformations, malignant neoplasms and intentional injuries. The risk reduction and prevention opportunities in this brief sketch are significant, with much known about evidence-based interventions. For persons born in 2003, life expectancy for NM males in 2003 was 72.6 years at birth, 1.9 years shorter than for US male; for females it was 77.4 years at birth and 2.5 years shorter than for US females.

N.M. DEPARTMENT OF HEALTH PRIORITIES AND TITLE V MCH PROGRAM ROLES AND RESPONSIBILITIES

The DOH restructured its Strategic Plan and is priorities in January 2005 when the new Cabinet Secretary assumed her position. The Department's priorities were condensed into 9 Program Areas.

The Title V Program is located in the Prevention and Disease Control Section of the Department. The six top priorities for this area of the Public Health Division are:

v immunization of children,
v prevention of teen pregnancy,
v improvement of the weight of adults and youth,
v prevention of youth suicide,
v prevention of the transmission of Hepatitis C,
v prevention and control of chronic disease.

The Title V Program's roles and responsibilities in this framework are to focus on teen pregnancy as well as improving the weight of adults and children as Department priorities for Program Area 1. For Program Area 2, the Department priorities are to improve access to medical and dental health services in agency-funded primary care centers. The Department is also focusing on improving access to WIC, Family Planning, Families FIRST Perinatal Case Management, and Children's Medical Services. These priorities are in line with Title V priorities and Title V is focusing on reducing disparities in program access. The Department also set a priority to increase the number of primary health care and emergency medical professionals supported or obligated per year and working in underserved areas as well as reducing the percentage of Medical and Dental provider positions vacant over 6 months in community-based health centers. The Department is also trying to increase the number of children screened for sealants by the DOH sealant program. The Department will also implement 34 new school based health centers in a priority move to improve access to health services, particularly for adolescents.

The Title V Management Team accomplished a review of selected Title V MCH specific performance measures and health indicators by population group, seeking input on what factors needed to be addressed to improve overall performance on the indicators and to address known gaps, disparities or barriers or build on strengths. The team reviewed access to and use of recommended primary, preventive and specialty care. Children with special health care needs were one focus of access to specialty care. The assessment was organized around 3 MCH populations: maternal and infant health in terms of women's health in pre-conceptional, prenatal and post-partum periods and infant health; child health ages 0-14, and youth health ages 15-21. This section of the assessment included the dimensions of community-based systems and the network of partnerships. In addition there were two topics representing cross cutting concerns: fathers and families; and MCH issues regarding immigrants.

Community input took place in four public health district sites in March-April 2005: Santa Fe,

Albuquerque, Roswell and Las Cruces. Each assessment exercise lasted 7 hours with 2 hours for formal presentations by FHB staff and 5 hours for soliciting input. After analyzing health indicator status, trends, gaps, and disparities, the FHB Management Team chose priorities for the Title V Program focus for the next 5 years.
The Title V Director and MCH Epidemiologist also take part in the assessment of early childhood needs throughout the year, using the Results Based Accountability (RBA) framework developed by the Fiscal Policy Institute of Santa Fe. The NM Children's Cabinet has derived the outcomes and indicators to address the well being of young children and their families from birth to 5 using this method. By using RBA for the Early Childhood Action Network action planning process, the two processes will be aligned and inform each other. The two large groups involved share the same language and definitions of the framework and can align their priorities.

/2008/All updates for section IIIA begin here. Unless otherwise noted, there were no significant changes from the previous year. The most current data are presented below//2008//

Population estimates
/2008/The July 1, 2005 New Mexico population estimate from The Bureau of Business and Economic Research (BBER) is 1,968,352; an increase of 39,968 from July 2004. There were 713,079 Children and youth aged 0-24 representing 36.2% of the population. Children aged 0-19 numbered 561,388 or 28.52% of the population. //2008//

Poverty
In 2004 an estimated 31% of NM's children lived in poverty compared to 23% for the U.S. The poverty rate, based on household income in NM, was 17%, in 2004. Four other states tied with NM the third highest rate of children living in poverty in the US. //2008/As of 2005, 30% of New Mexico's children were living in poverty, 7% more than the national average of 23%. Only Washington D.C. and Mississippi had higher percentages of children living in poverty. Source: www.statehealthfacts.org May 2005 and May 2006.//2008// /2009/The 2006-2007 estimated amount of NM's children living in poverty is 26% compared to 23% for the U.S. source: www.statehealthfacts.org//2009//

Healthcare Workforce Issues
The number of health professionals to serve the population in NM is decreasing. According to the NM Department of Health; Office of Primary Care and Rural Health (OPCRH): Every NM county has a type of Primary Care Health Professional Shortage Area classification, of which 16 have whole county designation and four have low income designations. /2008/Los Alamos county is no longer designated as having a Primary Care Health Professional Shortage. Source: NM Health Policy Comission 2007 Quick Facts.//2008// One hundred and fourteen J-1 Visa Waiver physicians are practicing in 20 NM counties; Sixty eight NM Health Service Corps stipend recipients completed their service in 19 counties in FY05, and 13 are currently serving in 9 counties; and Sixty five National Health Service Corps practitioners are practicing in 20 counties. (Source: NM Health Policy Commission 2006 Quick Facts).

Workforce to serve immigrants is lacking, especially in the border counties of Dona Ana, Luna, and Hidalgo counties. Prevalence of Hepatitis A and B are almost three times the national average. The workforce lacks sufficient Hispanic health professionals. Reasons for these shortages include lower salaries than national average, Medicaid financing barriers and aging health professionals. In NM, primary care, dental, mental health profession shortage areas are 17-42% greater than national average, thus community clinics are understaffed. The Title V Director served on a DOH management/University of NM Team that is assessing the need for management training of health professionals to increase the numbers of trained individuals to take management roles within the Public Health Division statewide. This included a needs assessment survey which was just distributed.

Health Insurance Coverage and Related Safety Net:
General Assistance

The number of General Assistance Cases increased from an average of 1096 per month in 2003 to 1977 per month in 2005. In 2003 the cost of that assistance was $4,164,461 and in 2005, the cost of that assistance rose to $7,282,384. /2008/From December 2005 to December 2006, general assistance increased by 12.6%, with a total of 2,055 being served in December 2006. State Fiscal Year spending for general assistance was $7,532,010. Source: HSD January 2007 Monthly statistical report.//2008//

Medicaid

The Medicaid report for June 2004 indicated the number of children enrolled was 275,444, an increase of 14,944 children. /2008/As of December, 2006, 272,156 children were enrolled in Medicaid. This was an increase of 13,970 since December of 2005. Source: HSD Monthly All Children Eligibility Report. //2008//In May 2006, Medicaid and its interagency partners were working to address the new federal rule regarding proof of citizenship for new Medicaid applicants and re-certification of current eligibles. The purpose is to reduce burden on eligible families and reduce interruption in coverage. As of April 1, 2006, Medicaid will pay nurse-midwives and direct-entry midwives licensed by DOH who attend births in homes and in birthing centers, on a fee-for-service basis. Medicaid and Medicaid MCOs will provide information on the out-of-hospital birth options to all new enrollees and to all members reported to be pregnant. MCO case managers will help low-risk pregnant women who choose midwife care to access it, and will help midwifes and clients access high-risk providers whenever complications arise that require them. Medicaid has proposed increasing the Federal Poverty level for the SCHIP population from 235% to 300% this will increase the number of eligible children with medical coverage in NM. /2008/This was defeated during the 2007 legislative session.//2008//

Medicaid will cover prenatal care for women at up to 235% of poverty, up from 185%, starting July 1, 2006. /2009/ This proposal did not get implemented. //2009// In addition, the state legislature allocated $1.7 million to Human Services Department for premium assistance to children and pregnant women to help them access health care. The program will start July 1, 2006, and the Medical Assistance Division is working to create policies and systems to implement it. /2009/ The Premium Assistance for Maternity (PAM) program expands health care coverage in for pregnant women. The program pays a portion of health insurance premiums for eligible women. In addition Premium Assistance for Kids (PAK) - Covers children ages 0 to 12 or up to 18 years old if part of a sibling group with a child under age 12 who are ineligible for the New Mexikids program due to income. The state assists with 50 percent of the costs of the premium. Premiums range from $70 to $180 per month. The PAK benefit package includes preventive, primary and specialty care, inpatient and outpatient hospitalization, pharmacy, lab, x-ray and physical, occupational and speech therapy. //2009//

Food Stamps

With regard to food insecurity, in 2002 NM ranked one of 5 worst states in the U.S. In 2002, US 10.8%, NM 14.3%. /2008/According to the 2005 USDA report on Household Food Security, an average of 16.8% of New Mexican households experienced low or very low levels of food security during 2003-2005. This was the highest level for any state, during that time period, and 5.4% higher than the national average. New Mexico ranked second, at 5.7%, for very low food security. Since the 2000-2002 survey, the average level of very low household food security for New Mexicans increased by 1.9% - the second greatest increase in very low food security in the nation (after South Carolina) Source: USDA Household Food Security in the US, 2005.//2008// While over 24% families with children lived at or below 100% of FPL, less than ¼ used TANF or cash assistance programs; Just over 1/2 of these households had someone in family using Food StampsFood Insecurity with Hunger NM ranked as 12th worst in the country. /2008/New Mexico is one of seven states that had both food insecurity and hunger prevalence rates that are significantly higher than the national average, according the October 2005 Center on Hunger and Poverty report //2008// The Food Stamps caseload was 95,574 during February 2006, a 2.8% increase from February 2005 (93,013). There were 997 more cases served this year. /2008/ The Food Stamp caseload during Dec 2006 was 93,255, a 3.1% decrease since Dec. 2005 when caseload was 96,193.//2008//

TANF
TANF Cash Assistance cases by county and region indicate that 470 (2.7%) fewer cases were served from February 2005 until February 2006. The total number of TANF cases has declined dramatically from July 1999, 21,436 cases to 15,101 cases as of February 2006. In January of 1999 TANF payments cost $10,367,566, whereas, in January 2006 those payments only totaled $5,304,253. /2008/There were 17,653 TANF cases in December 2005, and 15,244 in December 2006, representing a 13.6% decrease during that period. //2008// The Education Works Program expended an average of $144,745 per month and served and average of 415 persons in 2003 and in 2005, it expended $155,160.00 per month and served an average of 442 persons. /2008/During calendar year 2006, Education Works served an average of 394 cases per month, and spent an average of $137,569 per month. Source: HSD January 2007 monthly statistical report//2008//

Indian Health: MCH Epidemiology works closely with the Tribal Epidemiology Center of Navajo Nation and the proposed Tribal Epidemiology Center for Albuquerque Area; specific collaborations include use of NM PRAMS data. /2008/The new director of the Albuquerque Area Southwest Tribal Epidemiology Center is Francine Romero.//2008//

County Health Priorities: County Health Council efforts have gone into supporting the mental health consolidation process in the State to one provider for the entire state, Value Options. Local collaboratives have been created and collaborate with local health councils. While the local collaboratives and their development continue to face challenges, the process continues to move forward as planned. A Draft Matrix of Roles was developed that includes categories for the Interagency Behavioral Health Purchasing Collaborative; Local Collaboratives; Value Options; and the Behavioral Health Planning Council and Cross Agency Team staff. DOH collaborated with BHSD and HSD to interview candidates for a PHD representative on the Cross Agency Team. "The purpose of this position is to coordinate and/or provide training, education and technical assistance to local collaboratives, among judicial districts within PHD. This position will support efforts to build capacity and skills of local collaboratives to assess and effectively plan around behavioral health systems of care at the local level; identify and apply evidenced-based strategies for addressing locally and State identified behavioral health needs implement and evaluate State and community-based behavioral health activities This position will support the development of behavioral health plans by local collaboratives and assist communities to identify additional opportunities and resources.

NM Dept Health Priorities & Title V Program Roles - Responsibilities
The Department's broader priorities included improving access to healthcare, assuring quality in the health care delivery system, reducing disparities and achieving excellence in the administration and services provided by the Department. More specifically, priorities related to immunization, teen pregnancy, obesity, diabetes, hepatitis C, suicide and drug and alcohol abuse reduction among the state's citizens.

The DOH Secretary has created a new Office of Policy and Multicultural Health and its mission is to increase the capacity of the DOH and its partners to reduce gaps in health status and improve the quality of life of the state's diverse populations.

One of the top priorities for DOH was to increase immunization for children and adolescents. In 2004, the NM rate exceeded the national rate for the first time and NM became 15th among the states with fully immunized children. Title V played a major role in developing a CMS Flu database to assure CYSHCN received vaccinations during flu season and tracked follow up; 80% of at risk children received a flu shot. /2008/During 2006 there was a drop in the percentage of CYSHCN receiving flu shots from 82% to 66%. This was true only for families with an English-speaking adult. Families with no English-speaking adult maintained flu shots for CYSHCN at 82%. CMS and FHB are investigating the reason for this to develop an intervention strategy.//2008// Title V staff notified all midwives and PHD prenatal clinics CDC policy on flu immunization for pregnant women, and availability of vaccine. Midwives carried out patient

education on immunizations for infants and children by PHD offices.

The second DOH priority was to reduce teen pregnancy. Title V Director supervised the abstinence education program manager as well as the Title X Program Manager. The Title V Director staffed the Abstinence Advisory Council and served on the HECAT curricula screening tool committee and Evaluation Committee. Various curricula were reviewed for medical accuracy. An objective tool was devised to review curricula entitled the HECAT tool. There were several meetings with the Department Secretary and the Department Medical Review Committee as well as community members. The state devised a plan for administering both programs as a continuum. As a partial result of these strategies, of the 33 counties in NM, 14 counties have reduced teen births by 20% and seven counties reduced teen births by at least 10% between 1998-2003. /2009/ Abstinence will continue to be promoted through the Family Planning Program (FPP) in a comprehensive curriculum to include, however at this time the Abstinence program is not being promoted exclusively, or separately from the FPP. //2009// /2008/The current average birth rate per 1,000 15-19 year olds in New Mexico is 60.7. Seven counties have reduced their teen birth rates by at least 6% since the baseline data collected during 2001-2003. These counties are considered to be "on track" toward reaching the Family Planning Challenge 2010 goal of 15% reduction. In five counties, since 2003, the birth rate to 15-19 year olds has increased by more than 6%.//2008//

/2010/ The Family Planning Program (FPP) encourages teenagers who seek clinical services to communicate with their parents, helps them in responsible decision making about sex and encourages discussion of values and choices at home. One of the FPP priorities is to assure access to a broad range of acceptable and effective family planning methods and related preventive health services that include natural family planning methods, infertility services, and services for adolescents, including adolescent abstinence counseling. The FPP also provides a contraceptive method and/or a clinical exam visit. The clinical exam visit includes: a medical history/physical, laboratory tests, (including pap smear); testing and counseling for sexually transmitted diseases; family planning counseling; pregnancy testing (if needed); a supply of a contraceptive method of choice. A comprehensive health screening with mental health and drug abuse risk assessment may be provided. The services are provided statewide at: 49 Public Health Offices, 49 Primary Care Clinics, 26 School-Based Health Centers.
DOH provides various evidence-based teen pregnancy prevention education programs including: Comprehensive sex education; service learning programs; male involvement program; Adult-teen communication program,//2010//

Another priority of the DOH is to reduce child and adolescent obesity and diabetes. Currently, there are 3,508 WIC children at or over 95th percentile and 21,105 at 85th percentile. Over 22% of low-income children between 2-5 years of age who participate in the WIC Program are overweight or at risk for overweight. Of that number, 10% have BMI's over the 95th percentile. This has increased from 8.86% in 2000. /2008/2005 YRRS survey results show that 26.6% of New Mexico high school students are overweight or at risk of overweight//2008// In 2003, 57% of NM adults were overweight or obese. (CDC BRFSS, 2003). In NM, there are increased rates of diabetes and hypertension as well as arthritis-related illnesses all stemming from obesity in both children and adults. Estimated diabetes prevalence among NM adults shows that the statewide percentage of adults with diabetes is 8.4%. This number does not reflect the growing numbers of children under age 18 who are being diagnosed each day with diabetes. WIC clinics have been working on obesity prevention for several years with both classes on feeding relationships and other interventions. CMS clinics are seeing the effects of obesity in children and families as well. The Title V Director served as the NM designee for the Association of State and Territorial State Nutrition Directors. She also served as a liaison between DOH and the Public Education Department in the development and implementation policy related to Nutrition Standards for Competitive Foods in all public schools statewide.

/2010/In NM, there are increased rates of diabetes and hypertension as well as arthritis-

related illnesses all stemming from obesity in both children and adults. The 2005-2007 age adjusted incidence of diabetes among NM adults was 8.7. The estimated diabetes prevalence among NM adults shows that the statewide percentage of adults with diabetes is 8.4%. This number does not reflect the growing numbers of children under age 18 who are being diagnosed each day with diabetes. WIC clinics have been working on obesity prevention for several years with both classes on feeding relationships and other interventions. CMS clinics are seeing the effects of obesity in children and families as well. In 2007 the New Mexico WIC Program received a $390,000 grant from USDA to reduce childhood obesity. The WIC Program is partnering with the University of New Mexico and the International Life Science Institute Research Foundation to implement this project called Get Healthy Together: WIC Staff and Clients Moving Toward Healthier Lifestyles. This project will include staff wellness and self-efficacy training. In addition, this project will implement obesity management skill trainings to WIC staff in order to provide pediatric overweight prevention and behavior management counseling. In addition this project will incorporate Motivational Interviewing (MI) Training, which is a new tool that will be used by newly trained WIC staff to use on clients. The goals of the Get Healthy Together project are two-fold:
1. To increase New Mexico WIC staff self-efficacy regarding management of personal health behaviors associated with nutrition, physical activity and sedentary behaviors, and 2. To improve WIC staff counseling skills with WIC clients related to pediatric overweight prevention and management.

WIC Director Deanna Torres is the NM designee for the Association of State and Territorial State Nutrition Directors.//2010//

Reduce youth suicide: Potential causes of youth suicide include: Poverty, Historical Trauma, Racism, Depression/other mental health diagnosis, Substance abuse, Drop out, Academic Failure, Isolation/physically-emotionally, Abuse- physical, sexual, emotional, Assimilation conflict-cultural conflicts, Oppression, External Locus of Control, Addiction. The Title V Program placed the Adolescent Health Educator within the Office of School Health to help implement School Advisory Councils which would provide better support for youth development activities within schools. /2008/According to the CDC/WISQARS 2004 report on youth suicide, 36 New Mexican youths aged 15-19 committed suicide in 2004//2008///2009/ According to the CDC/WISQARS 2005 report on youth suicide, this number has decreased to 23 New Mexican youths aged 15- 19 committed suicide in 2005.//2009//

A priority of DOH is to reduce tobacco use. This year the NM Department of Health gave almost 1,700 New Mexicans free nicotine replacement products in a special program to help tobacco users quit. In less than one month's time, more people called the department's tobacco help line and registered for services than in all the prior nine months combined.

Title V contributed to data analysis which established the Healthy Birth Index for pregnant women, tracking smoking rates during pregnancy. Title V placed that index on the Children's Cabinet Report Card which was distributed across all State departments and to the State Legislature. /2008/Nine percent of 2005 New Mexico PRAMS respondents reported smoking during their last three months of pregnancy.//2008//

Title V has been directly involved in the reduction of sexually transmitted diseases, supervising the Family Planning Program Manager and supporting her issues related to pharmacy costs, lab fees related to Chlamydia cases this year. Title V supports Family Planning confidential services to teens. /2008/In 2006, 14,761 adolescents ages 13-19 were seen for family planning services at local health clinics//2008// /2009/which included 1,041 teens under 15 years, 7291 teens 15-17 and 6,411 teens 18-19.//2009//

Another priority of the DOH is to expand healthcare access in rural and underserved areas.

While the current strategy is to expand tele-health, Title V worked with the APP to reinstitute the one year recertification for Medicaid through the Early Childhood Action Network. /2008/Their efforts were successful.//2008//

DOH would like to improve access to preventive and restorative oral health services. NM is one of 16 states with no dental school, and recruiting dentists is difficult. NM has lost 19 licensed dentists between 2004 and 2005. /2008/The 2007 Federal standard for dentists is 1 FTE dentist per 1050 people; NM's median is 1 FTE dentist per 3,297 people. Three Counties have no full time dental service. NM has many health professional shortage areas for dentists, an aging workforce, and no solution in the near future. Source: HPC 2007 Quick Facts.

/2009/ In 2005 New Mexico has 871 licensed Dentists with a New Mexico practice address. There were approximately 4.58 Dentists per every 10,000 people in New Mexico. Nationally the ratio of Dentists per 10,000 is 5.83 and is expected to decline to 5.37 in th year 2020. Source: Health Policy Commission 2007 Quick Facts//2009// /2008/About 6% of women reported in the 2005 PRAMS sample that they were abused by a husband or partner during pregnancy, basically unchanged from previous years. This fact was included in the Children's Report Card. The Governor's Task Force on Oral Health met regularly and produced a comprehensive report. to the state legislature on In collaboration with the Office of Injury Prevention, FHB is using the technical assistance provided through a Safe Families Action Learning Lab two year grant received from AMCHP and supported by CDC. Through grant supported assistance from the Family Violence Prevention Fund, family violence prprevention is being integrated into MCH TV programs. Also, MCH TV and safety advocates successfully supported childhood in jury prevention during the 2007 legislative passage of the Child Helmet Safety Act requiring helmet use while using non-motorized recreational vehicles used on public property//2008/

B. Agency Capacity

B 1: The New Mexico Title V program for Children and Youth with Special Health Care Needs (CYSHCN) is titled the Children's Medical Services (CMS) that collaborates with partners statewide. With limited resources, CMS has maximized its capacity to ensure an effective system of statewide services to CYSHCN.

State Program Collaboration: CMS collaborates with and receives funding from the State Laboratory Division and UNM Metabolic Consultants in the provision of Newborn Genetic Screening. CMS works with the School for the Deaf, STEP HI Program for newborn hearing screening and follow-up; CASA, TUPAC, WIC, the ARC and UNM Hospital OB GYN Department for the Birth Defects Registry and Neural Tube Defect surveillance and prevention. CMS also collaborates with the Health Systems Bureau for networking with the RPHCA funded centers. The NM Sickle Cell Council provides education, screening and follow-up for sickle cell and other hemoglobinopathies. CMS partners with the WIC program in the Navajo Division of Health, Navajo Nation, in education regarding use of folic acid to prevent birth defects. /2008/CMS is working with Medicaid to increase funding to pediatric providers, midwives and hospitals for expanded Newborn Screening. Medicaid and CMS work together to increase enrollment of children due to expanded eligibility requirements. CMS is working with the Commission for the Deaf and Hard of Hearing and the Commission for the Blind and Visually Impaired to address unmet needs for children in these communities.//2008//

/2010/ The Child Health program applied and was awarded the Project LAUNCH grant given to six states to include one tribal entity. This grant requires a multi agency team work with the Early Childhood Comprehensive Systems (ECCS) team to create a comprehensive strategic plan that all agencies can provide input and have similar goals in which to work towards. The ECCS workgroup in New Mexico also known as the Early Childhood Action Network (ECAN) has worked for several years with other state and private entities towards early childhood services and advocacy. Combining these two groups will enhance the work provided by the multi-agency team and ECAN to push early

childhood issues forward.//2010//

State Program Support for Communities: CYSHCN who are covered by Medicaid/SCHIP and other insurance can receive clinic services in multidisciplinary CMS/UNM pediatric specialty outreach clinics, and care coordination by CMS social workers. Children under three with complex medical diagnoses go though the CMS Family, Infant Toddler Program (FIT) and are transitioned to CMS CYSHCN social workers at age three, assuring ongoing medical management and coordination of care.
/2008/The number of children enrolled into NMMIP will increase by 80 with an emphasis on meeting unmet orthopedic needs. Additionally, the legislature approved $300,000 to be used in CMS specialty clinics.//2008//***/2010/ CMS added 10 more asthma clinics statewide and enrolled 50 clients onto NMMIP//2010//***

Coordination with Health Components of Community Based Systems: CMS's network of 60 social workers is located and co-located with other health services in NM. They coordinate health care for CMS CYSHCN statewide. CMS works with community councils and services with the Title XVIII Medicaid and Title XXI SCHIP program, the largest providers of medical care, in an effort to provide and model family centered, community based, culturally competent coordinated care. /2007/CMS social workers provide a statewide system of oversight and care coordination for infants identified through the Newborn Genetic Screening and Newborn Hearing Screening state mandated programs, ensuring that they receive a continuum of care. After initial care for the first 3 years under the CMS/ FIT, children are transferred to CYSHCN social workers to continue care coordination.

House Bill 479 was passed in the 2005 legislation that will require expanded screening for all newborns born in the state of New Mexico, from six diagnoses to 28. CMS is working with the State Lab, Genetic Advisory Committee and Pediatric Advisory Board to strengthen the follow-up. The CMS CYSHCN Program and the State Lab Division are working together to select an outsourcing laboratory for tandem mass genetic screening. The expanded screening is expected implementation in the summer or fall.//2007//

/2008/Oregon State Public Health Lab (OSPHL) was selected to provide testing and follow-up for the Newborn Screening program. Oregon provides short term and long term follow-up with their genetic and metabolic experts directly to Primary Care Providers (PCPs) who are caring for newborns with presumptive or confirmed screens. OSPHL coordinates with UNM Metabolic specialists after diagnosis.//2008//

Coordination of Health Services with Other Services at Community Level: Healthy Transition New Mexico is coordinated through the Healthy Transition Coordinating Council with representatives from DVR, Medicaid, and Salud!, CMS, UNM LEND Program, UNM Family and Community Partnerships Division of Center for Developmental Disabilities, Parents Reaching Out, and Statewide Transition Initiative Participants to address medical and psychosocial issues of adolescent YSHCN transition.
/2010/ CMS has applied to HRSA for the Integrated Services Grant which will focus on youth transition and Medical Home.//2010//

The CMS transition team has developed a model multi-cultural, bi-lingual transition plan. //2007Agencies and community partners include: CYFD/child protective services, Food Stamps, ISD, community organizations providing services to multicultural populations, i.e. Somos Un Pueblo Unido, local and statewide family organizations, school systems, some faith based service organizations such as Catholic Charities, and community domestic violence and substance abuse coalitions.//2007// Agencies and programs receiving Title V Maternal and Child Health Funding participate in a MCH Collaborative addressing transition, Medical Home and other MCH initiatives. Enchanted Rainbow continues the work of Double Rainbow with statewide representation, with a focus on children birth to age five, autism, immigrant health, and infant mental health. /2008/Enchanted Rainbow has stopped meeting due to a lack of funding and

leadership. There had been improved attendance by the Managed Care Organizations (MCOs). The Regional offices in regions 1 and 3 arranged for a presentation by 2 of the MCOs regarding working with their CYSHCN case managers which did help improve communication between programs. CMS is represented on the Family to Family Health Advisory Board with Parents Reaching Out (PRO). The Newborn Hearing (NBH) Coordinator participates on the Deaf/Hard of Hearing (D/HH) Task force at New Mexico School for the Deaf (NMSD) to address unmet needs of D/HH children in their communities. Task force members include NMSD, parents; Commission for D/HH, PED, and local school districts.//2008// ***/2010/ CMS Medical Director participates on Multi-Agency Task Force on Early Childhood services in NM//2010//***

/2007/The change in Secretaries of DOH occurred once again, and the new Secretary has brought a broad vision regarding the health of New Mexicans. The Secretary, appointed by Governor Richardson has supported the Governor's Health Insurance for All initiative. The recent legislative session produced additional coverage for uninsured children aged birth to five. The changes include an increase of Medicaid eligibility through income disregard to 300% of FPL for children age birth to five, and the "Every Child Zero to Five and Prenatal care" Premium Assistance program for children who are not Medicaid eligible. The six-month renewal requirement was rescinded by Governor Richardson. The renewal process will return to annual. A grant proposal was submitted to HRSA/MCH including the creation of a statewide council for integrated services for CYSHCN. This proposal addressed all CYSHCN goals in an integrated fashion. Experts were identified as key participants to address the medical home with experts including Trish Thomas from Family Voices, Dr. Aceves, Sally Van Curen from Parents Reaching Out. Dr. Nelson, medical director for Presbyterian Salud! and the Navajo Nation.//2007// /2008/CMS was not awarded the HRSA funding. However, the Navajo Nation was awarded and is collaborating with CMS to address Youth Transition.//2008//

B 2: Agency Capacity: Statutes

The NM Public Health Act gives DOH authority and power to regulate the practice of midwifery. The Maternal Health Program administers this. A bill was passed in the 2002 legislative session that mandates newborn hearing screening in NM. NM passed a bill to cover medical diets for Genetic Inborn Errors of Metabolism effective July, ‘03. The act required health insurance to cover medical diets required to control Genetic Inborn Errors of Metabolism; enacting section of the NMSA 1978.

Confidential services and minors: Parental consent is not required for, and lack thereof shall not bar children from receiving pregnancy testing, diagnosis and treatment of sexually transmitted disease, family planning services and H.I.V. testing pursuant to the Family Planning Act- Section 24-1-13, NMSA 1978, Section 24-2B-3, NMSA 1978, and 42:U.S.C.A. Section 300 et.seq., 42 C.F.R. Section 59, 42 U.S.C.A. Section 1201 et.seq., 42 U.S.C.A. Section 1296 et.seq. The recent legislative session produced additional coverage for uninsured children aged birth to 5. /2008/The following MCH-related bills were passed in the 2007 legislative session: HB613 Safeguarding a nursing Mother's right to use a breast pump in the workplace and to have a flexible break time in which to use it; HB721 Specifically adds representatives from pueblos, tribes and Indian nations to county Maternal and Child Health Planning Councils; SB23 Amends the definition of "public employee" in the Tort Claims Act to exclude all health care providers licensed in New Mexico who render voluntary services on behalf of a governmental entity without compensation, thereby providing immunity from tort liability for such providers. SB407 Requires that individual or group health insurance policies, health care plans or certificates of health issued or renewed in New Mexcio provide coverage of the HPV vaccine to females aged 9-14 years. SB397 Makes it unlawful for a parent or legal guardian of a minor to knowingly permit that minor to operate or be a passenger on a bicycle, skates, scooter, or skateboard unless that minor wears a well-fitted protective bicycle helmet.//2008//

B 3: The Maternal/Child Health (MCH) Section:

Preventive and Primary Care Services for Pregnant Women, Mothers and Infants:

In 2003, over 54% of New Mexico's pregnant women and infants had care paid by Medicaid and S-CHIP through its Managed Care Organizations (MCOs) and fee-for-service sites. The Maternal Health Program (MH) oversees direct prenatal care services in 13 of the 54 local health offices (LHO). The LHOs provide prenatal care for about 800 women who otherwise would not have access. MH reimburses ~ 20 qualified private care providers who care for ~1000 medically indigent women with high-risk pregnancies per year. MH has agreements with the University of New Mexico Hospital (UNMH), the state's provider of last resort, to provide prenatal care to about 500 low-risk medically indigent women in Albuquerque, and also to provice high risk prenatal care, at no cost to the patient, to all medically indigent women with high risk conditions who present to them. This includes non-routine prenatal laboratory services, ultrasounds and non-stress tests. In 2005, MH initiated meetings with the Health Systems Bureau, which administers state grants to primary and rural health care clinics, to evaluate availability of prenatal care services throughout the state. MH regulates and licenses the practice of licensed midwives (LMs) and certified nurse midwives (CNMs). In 2000, over 26% of births in New Mexico were attended by CNMs. Thirteen of the fifteen CNM practices in New Mexico were started in 1997, when CNMs became independent practitioners.

/2010/ Public Health Offices in 8 locations in the south part of the state provide prenatal care for approximately 650 women per year who are financially or geographically unable to obtain prenatal care. Maternal Health Program has capped agreements with University of New Mexico Hospital (UNMH), the provider of last resort for the state, with seven obstericians, and with nine hospitals and sonographers, to provide risk-appropirate prenatal care for about 1300 medically indigent women who otherwise would not be able to access it. Services by UNMH include high risk outreach clinics in 5 counties. Maternal Health Program also has an agreement with University of New Mexico Hospital, whereby 412 medically indigent women receive low risk prenatal care. A similar Maternal Health Program agreement uses New Mexico General Funds to pay for perinatal services for 150 medically indigent women in Las Cruces. In late 2008, Maternal Health Program did a phone survey of delivery services in each of New Mexico's 33 counties. 12 of the 33 counties have no hospital that provides delivery services except in emergencies. 11.6% of the state's births in 2006 were to residents of these counties. A survey of physicians by the New Mexico Health Policy Commission in 2001 showed that 13 (40%) New Mexico counties lacked an Ob/Gyn practicing obstetrics. In 2006, a repeat of the survey showed that 17 (51%) counties lacked an Ob/Gyn practicing obstetrics. Between 2005 and 2008, three hospitals terminated delivery services, None that had not previously had it started it up. Only 9 counties have providers of out-of-hospital deliveries.

Increasing liability insurance premiums and low reimbursement rates have driven some providers to leave the state or to quit obstetric services. The state is developing proposals to the legislature for alternatives to the torts system for compensating those who suffer poor birth outcomes and for reducing negligent practice. Besides improving the quality of care, it is hoped that such an administrative system could reduce the burden of liability insurance costs and the stresses of litigation, thus potentially increasing the number of obstetric providers and the public's access to them.//2010//

The Families FIRST Program (FF) will join the MCH Section. FF receives no Title V funds; it is supported by contracts with the MCOs. The goals and activities of the FF Program fit with those of the MCH Section. Partnering with FF will strengthen the Section's ties to direct services. FF provides case management for Medicaid-eligible pregnant women and children 0-3 years. Its goals are to improve birth outcomes, to decrease high-risk pregnancies and identify children with special health care needs for early intervention. FF case managers conduct verbal assessments of the mother and child's health including emotional, social, educational and other needs. The FF CMs refer clients to needed services, including nutrition counseling, parenting classes, and education sources. FF has contracts with the three Medicaid MCOs. It has case management

providers in 45 sites. The number of clients served increased by about 80% from 7/01/01-6/30/04

/2010/The Families FIRST Program (FF) is part of the MCH Section. FF receives no Title V funds; it is supported by contracts with Medicaid MCOs. The goals and activities of the FF Program fit with those of the MCH Section. Partnering with FF strengthens the Section's ties to direct services. FF provides case management for Medicaid-eligible pregnant women and children 0-3 years. Its goals are to improve birth outcomes, to decrease high-risk pregnancies and identify children with special health care needs for early intervention. FF case managers (CMs) conduct verbal assessments of the mother and child's health including physical, emotional, social, and educational needs. The FF CMs refer clients to needed services and resources, including nutrition counseling, parenting classes, and education sources. It has case management providers in 28 sites statewide. The number of clients served in FY 07 was 3371, and in FY 08 was 3061. //2010//

The Family Health Bureau's (FHB) marketing initiatives included: development of a newborn genetic screening video, brochure, poster, and other marketing materials; a "Day Two" booklet on toddlers' behavior and their parents' feelings; billboards with messages about prenatal care; a video on domestic violence and its impact on children; focus groups of adolescents asking why they do not start prenatal care early;. In 2004, Children's Medical Services implemented a pilot study on the Navajo Nation and in the counties, called Life Long Happiness. This preconception education project promotes use of folic acid, alcohol and drug avoidance, proper diet and exercise for women of childbearing age to decrease birth defects. In 2005 WIC adopted the curriculum, and will use it in their clinics statewide. ***/2010/In 2006, WIC also developed 3 PSAs for television to educate families that babies should be breastfed throughout the first year of life, and why and how fathers can support breastfeeding. The PSAs aired on all major networks through the fall of 2008. In addition a collaborative project with CDC to create a model breastfeeding-friendly community for the state in Grants, New Mexico//2010//***

The MCH Section will add an MCH Epidemiologist position, funded by the State Systems Development Initiative (SSDI). This position will coordinate Title V Block Grant reporting, including collection and evaluation of MCH data; work on special projects funded by the SSDI and Early Childhood Comprehensive Systems grants; and fill other MCH program data needs. ***/2010/ The MCH Epidemiologist position was transferred to the MCH Epi program in 2008. The duties remain the same, it appears to be better suited in this program.//2010//***

/2007/State funding for prenatal care will increase eligibility for Medicaid coverage from 185% of poverty to 235%, beginning July 1, 2006, and supplement insurance premium payments for some insured women and young children ***/2010/Legislature did not pass this initiative. Eligibility for pregnant women remains at 185% FPL.Families FIRST case managers are now able to enter PEMOSAA information directly into the State's Human Services Division online system for children 0 to 3 years of age.//2010//***

Due to short staffing only nine PHOs now provide prenatal care and MH covers only 425 low-risk women's care at UNM HSC. CNMs attended 31% of births in 2003. In April 2006, Human Services Department initiated Medicaid payments for out-of-hospital birthing services. Increasing rates of liability insurance endangers obstetrical services. NM Health Policy Commission is studying alternatives to a liability system to assure quality of care and support for those suffering poor birth outcomes.

FF's contract association with Presbyterian, the largest Medicaid MCO, ended June 30, 2005. FF has maintained its sites, but reduced funding may force it to cut back.***/2010/ Currently FF is negotiating with Blue Cross/Blue Shield, the new contracted MCO with Medicaid to provide FF case management services to eligible pregnant women and children.//2010//***

FHB has no new marketing initiatives due to lack of funds.//2007//

/2008/In July, 2006 two new programs went into effect that will increase access to care for families that otherwise might not be eligible for Medicaid: Premium Assistance for Maternity (PAM) program, which covers pregnancy- related services, and the Premium Assistance for Kids (PAK) program which offers assistance for premiums for a commercial, comprehensive health insurance plan for children.

Due to the loss of FF's contract with Presbyterian, the number of families served decreased to 3,619 in FY06. Beginning in July, 2007 the FF program will convert to use of an electronic medical record, to improve data collection and analysis. MH activities continue as above. This will greatly enhance the program's ability to produce outcome data.//2008//

/2009/The FF Program served 3371 families in FY 07-08 and is currently using Challenger software electronic medical records to improve data collection and analysis.//2009//

/2010/ In 2008 and 2009, the Maternal Health Program conducted their first county by county phone surveys on prenatal and delivery services to collect information on services and gaps. They hope to repeat the surveys annually. //2010//

B 4: The MCH Health Section: Preventive and Primary Care Services for Children

The Child Health Program is being revised to reflect a broader spectrum of activities in child health. Statewide objectives are to promote and establish comprehensive policies that impact children and youth, assess and maximize resource allocation, remove administrative barriers to obtaining departmental services and assistance, to track New Mexico indicators concerning child and youth well-being, and to encourage partnerships that elevate the conversations, expertise, research, and action regarding New Mexico's Children and Youth.

In 2005 the first Childhood Report Card was produced that defines indicators to measure progress on all five of the Children's Cabinet outcomes for children birth to age five; the Early Childhood Health Programs Budget, which catalogues all of the Department's investment in young children and their families and advocates for shifting funding from intervention to prevention that will save taxpayer dollars in future years. It will also produce a Short Term Policy Agenda for fiscal year 2007 and a Long Range Strategic Population Level Plan.

/2007/In January 2005 a total of $250,000 was appropriated by the State Legislature to plan, develop, and implement a program to provide home visits to New Mexico families with newborn babies. The program was implemented in two counties, Santa Fe and Dona Ana. The first visit took place in October of 2005 and to date the program continues to grow. The program objectives are to establish a medical home for the families, educate and provide educational materials to families about preventive issues such as immunizations, consequences of smoking and exposure to second-hand smoke, benefits of breastfeeding, promoting the strengths and benefits of the family unit, and child development, and to make needed referrals to existing community resources.
The home-visit program was implemented to provide preventive and primary care services to children and to address the 21,000 New Mexico children, 5 years old and under who are uninsured.***/2010/The pilot program was discontinued //2010//*** In February, 2006 the Governor signed a bill that implemented a new program designed to help extend health insurance to children. The program pays a portion of health insurance premiums for about 5,000 children, 5 yrs. and under who are not eligible for Medicaid and don't have health coverage, and will provide monies to try to enroll the estimated 16,000 children who are eligible for Medicaid but are currently not enrolled.

The Family Leadership Action Network (FLAN), is a network of families linked together to promote the voice of families to influence policies and programs that affect them. In conjunction with Parents Reaching Out (PRO), hosted a 3 day forum with workshops and speakers on how to best advocate for their children and family. The workshops were Early Intervention, Children at

Risk, Special Education, Access to Health Care, and Systems Change. Families from throughout the state were given the opportunity to voice their concerns and listen to the concerns of other parents. "Children do not come with instructions on how to deal with the difficult circumstances that many families experience" These families were able to connect with one another to share experiences, information, new ideas and offer support. Well informed and empowered families who can tell their story can make a positive difference in education and healthcare.//2007//

/2008/A second Family Leadership Action Conference was held in May of 2006; 70 families attended. Specific family leadership training was conducted around how to tell a family story to policy makers and how to advocate for the needs of young children.

The New Mexico Early Childhood Comprehensive System (ECCS) grant has been instrumental with the establishment of a new level of collaborative infrastructure to address improving outcomes for children from birth to 21. NM now has a functioning Children's Cabinet established in statue to advance cross-agency systems alignment. In May of 2006, the Lt Governor re-appointed 43 Early Childhood Action Network (ECAN) steering committee members representing families, early childhood experts from health, early learning, education, child development, business, media, faith, philanthropy, higher learning and key state agency staff for another 2-year term. The ECCS initiative in New Mexico has produced prototypes of both a report card and an inventory budget of early childhood programs as part of the ECCS environmental scan and strategic planning process. These products served as a foundation for the Children's Report Card in 2005, 2006, 2007 and the Children's Budget in 2007. The ECAN established in 2004 is now a fully functional and engaged group. An Executive Leadership committee formed to guide implementation of early Childhood Strategic Plan and an Early Childhood Policy group formed to work with State Agencies and Legislative Leadership. Members of the ECAN serve on the New Mexico Children's Cabinet, regularly communicating with State Agency leaders as well as New Mexico state legislators.//2008//

/2010/ In response to a SAMHSA Request for Applications, the Child Health Program applied for and was awarded the grant, Project LAUNCH (Linking Actions for Unmet Needs in Children's Health), in 2008. LAUNCH promotes wellness of young children, birth to eight, creating a shared vision that drives the development of networks for the coordination of key child-serving systems and the integration of behavior and physical health services. Working in cooperation with the ECCS initiative and Project LAUNCH, a state-wide early childhood comprehensive systems strategic plan is being developed that is broad enough to guide all of the early childhood system's building work in New Mexico, irrespective of multiple funding streams. A multi-agency team of program-level managers meets monthly to coordinate activities and consider ways to build infrastructure and systems that will benefit children and families. Other initiatives and projects, such as ECAN and FLAN, continue to be successful in promoting practices and policies for early childhood development and family involvement and building public/private partnerships and collaborations. //2010//

/2009/ The New Mexico Children's Report Card has been produced annually for four years. In 2007 the first Children's Budget was added. FLAN continues to host an annual conference that attracts families from throughout the state. The 2007 conference featured speakers and activities in early brain development and the importance of play. The ECCS grant supported the establishment of the Early Childhood Action Network (ECAN). The lieutenant governor appoints members to serve two-year terms on the steering committee of ECAN. New members will be appointed in June 2008. ECAN holds two large conferences a year: a policy summit each fall in order to set a policy agenda that is presented to the legislature to put early childhood issues at the forefront and improve the well being of young children and their families and a spring conference to "Turn the Curve for Young Children and Their Families." A subcommittee of ECAN prepared a document, "Improving Developmental Care for Young Children and Their Families in New Mexico." The report provided recommendations for improving the quality of developmental screenings in child health care and early learning settings in New Mexico. Approximately 1600

copies were distributed to physicians and other medical professionals, early care and education providers, parents, and state legislators. //2009//

B 5: Services for CSHCN

The Title V CYSHCN program prepared a model for the development of a statewide council to oversee efforts to improve care in all areas. The Title V CYSHCN Program, CMS, works closely with UNM Continuum of Care, the Lend Program, Parents Reaching Out, Family Voices, the Health Systems Bureau RPHCA funded clinics, 1000 providers statewide, the NM Pediatric Society, the Medicaid/S-CHIP Salud! Programs, Indian Health Services, Long Term Services and the Family Infant Toddler Program. /2008/The CMS Medical Director and the CYSHCN Program Manager are participants in a newly created Pediatric Council. Council members include the NM President of the Pediatric Society and pediatricians representing practices around the state, the Managed Care Organizations (MCOs) and Medicaid. The Council was established to allow a forum for pediatricians and insurance payors to meet and address policy and process issues that affect the ability of practitioners to provide health care to NM children. The Council is addressing asthma as its first order of business. An asthma summit is also being planned for fall of 2007 to address the need for a comprehensive plan for pediatric asthma. Key stakeholders include Department of Health, Indian Health Service and University of New Mexico, rural community providers, the MCOs, school based health centers, and school health.//2008//***//2010/ The Asthma Summit was completed in 2009 and follow-up activities in the regions are ongoing.//2010//***

/2007/Through a collaborative effort between CMS staff, Robertson High School and NM Highlands University in Las Vegas, the mentoring pilot project between the university and high school continues. A plan for the development of a Peer Mentoring Transition Project for the Navajo Nation is also being proposed. The Champions for Progress Grant is funding a Statewide Train-the-Trainer Retreat for attendance by regional teams. Training topics concerning transition issues will be presented along with a panel discussion of what was learned in the mentoring pilot project. /2008/Due to unforeseen circumstances a Retreat was not possible. Training in topics pertinent to youth transition, including a videotaped presentation from the mentoring pilot project panel, was delivered to 4 regional teams. These teams plan to implement the use of "The Real Game" curriculum in selected high schools across the state by utilizing tools given during this training.//2008//

The inspirational transition training video "What Comes Next?" - funded through HRSA technical assistance was completed. The CMS Transition Team is creating a guided discussion tool to accompany the video, and will include information for different audience participation (i.e. viewing the video with services providers or with families), and resources for YSHCN. The video will be distributed to CMS Staff, HTNMCC Council and other partners working with YSHCN. CMS continues the insurance assistance program by paying for premiums and deductibles for qualifying clients enrolled in the New Mexico Medical Insurance Pool. This gives clients a head start on obtaining medical insurance once they transition out of the Program.//2007//

/2008/The guided discussion tool is near completion. The film has been edited, so previous captioning in English and Spanish must also be edited. Once all appropriate approvals are received, distribution plans will be developed for use of both the video and discussion guide.//2008//***2010/CMS is having difficulty getting a contract through the Division to pay for captioning in English and Spanish due to state economic difficulties. The plan is to try again next fiscal year.//2010//***

The Social Security Administration's (SSA) December 2003 report on Children Receiving Supplemental Security Income (SSI) showed New Mexico had 6,628 children under age 18 receiving benefits. Average monthly payments in New Mexico are $478.28 per month. The New Mexico SSA office is not able to provide a state breakdown of SSI recipients by ethnicity or age. SSI beneficiaries are offered care coordination services by the CMS CYSHCN program. Medicaid Salud! Coverage in New Mexico is comprehensive; CMS pays for medical services for families

when their monthly income exceeds SSI limits (but still falls within CMS financial eligibility guidelines). CMS Social Workers assist SSI recipients turning 18 to apply for benefits as adults. /2008/ The Social Security Administration's (SSA) December 2005 report on Children Receiving SSI showed New Mexico had 7,640 children under age 18 receiving benefits. Average monthly payments in New Mexico are $518.49 per month. The New Mexico SSA office is not able to provide a state breakdown of SSI recipients by ethnicity or age.//2008//

/2007/The most current data shows that 5.2% of state SSI beneficiaries less than 16 years of age and an additional 61 % children and youth were eligible for rehabilitative services from the State Children with Special Health Care Needs Program. There appears to be a decreasing trend in this measure over the past five years, due to the level funding allocated for these services during this period. There continues to be concern over a gap in coverage for services addressing chronic orthopedic and rehabilitation needs of uninsured children and youth in New Mexico. The merger of Carrie Tingley Hospital (which used to provide these services to children with no insurance, Medicaid, or other payor source) with the University of New Mexico (UNM) Medical Center resulted in a change in the coverage of rehabilitative services. Currently, UNM Carrie Tingley Hospital is not providing rehabilitative services to patients unless they are able to pay out of pocket. The Children's Medical Services (the state CSHCN Program) has recently made a small inroad in this area by placing children and youth with special diagnoses on the New Mexico Medical Insurance Pool. This is the only way that children and youth with special health care needs who do have diagnoses that includes orthopedic will receive orthopedic coverage. In addition, the coverage is far greater than the $15,000 limit for CMS CYSHCN and far more comprehensive. The gap in coverage for chronic orthopedic and rehabilitative services described above results in disparate coverage for immigrant (mostly Hispanic) children, since most are unable to pay out of pocket for such services. Funding was appropriated by the Legislature to Carrie Tingley Hospital in the l980's. Until this funding is shared with the Title V CYSHCN Program, no services will be provided to immigrants who do not qualify for SSI Medicaid. Since learning of the CMS CYSHCN effort to place children and youth on New Mexico Medical Insurance Pool (NMMIP), Carrie Tingley is now placing them on NMMIP before referring to CMS. While this appears helpful, it may represent greater cost to the CMS program as some diagnoses cost less than the NMMIP deductible and co-pay. SSI and Medicaid/SCHIP continue to be the major providers of the rehabilitative care in New Mexico.//2007//
/2008/The 2007 Legislature appropriated $500,000 to CMS to expand coverage to CYSHCN who are non-Medicaid eligible. CMS is proposing to enroll 80 children on NMMIP with specific emphasis on those children who are already receiving comprehensive services which do not presently include orthopedic needs.//2008//***/2010/ CMS and Carrie Tingley continue to work on reaching an agreement to provide orthopedic care to non-Medicaid eligible children. CMS continues to expand coverage with NMMIP//2010//***

B 6: Culturally Competent care that is appropriate to the State's MCH population:

The Maternal Health Program (MH) focuses cultural competency in prenatal care (PNC) on meeting the needs of Mexican women and Native American women. The ten Local Health Offices providing PNC each have native Spanish-speaking clinical staff or expert translation available for clients. A native Mexican Nurse Practitioner and a native Mexican M.D serve three of these clinics. Maternal Health contractors provide Spanish-speaking clinical staff and/or expert translation for clients who speak Spanish only, and where possible, for speakers of other languages.

Focus groups of Hispanic young women and of Navajo women, young, older, urban and rural, have guided PNC promotion. MH actively promotes a model of Facilitated Group PNC (FGPNC) to improve cultural relevance for all women. This model has been proven to increase satisfaction with and attendance at PNC, as well as self-care and breastfeeding. MH helped six clinics develop FGPNC for Spanish-speaking women. Two agencies in Albuquerque provide FGPNC exclusively for teen mothers and their partners and support persons. Efforts to support Indian Health Service clinics in starting a group PNC option continue. MH and Health Systems Bureau

collaborate to identify cultural barriers to PNC, and to eliminate them.

Family Planning (FP) trains health office and contractor staff and gives technical assistance to assure services are culturally appropriate. Materials are translated. Translation is available when services are provided. FP audits local Title X providers' cultural competence. FP's provider agreements (PAs) and contracts state: " . . . providing language assistance (verbal and written) is necessary to ensure access, at no cost to the person at every clinic." Providers and contractors will be required to send a copy of their limited English proficiency (LEP) policies and procedures for review, and to develop their own list of interpreting and translating resources. At the yearly audits, the LEP policies and procedures are reviewed for compliance.

The DOH website will post the Limited English Proficiency policy and a statewide list of translator/interpreter resources.

The CMS CYSHCN Program has been selected for its work in cultural competence for the Georgetown National Center for Cultural Competence monograph on best practices in cultural competence.

In response to an assessment done with the National Center for Cultural Competence in 2000, CMS has made great strides in cultural competency. CMS staff participates in the DOH's Increasing Minority Participation Task Group (IMPART). IMPART has developed and implemented an Intercultural Communication Training Module. This is a series of exercises to build intercultural communication skills. It has developed a library, listserv and speaker's bureau and organized videoconferences and research seminars. Staff have formed or joined other multi-disciplinary cultural competency committees such as the Immigrant Task Force that plan trainings on cultural competency, linguistic access and health disparities. All staff members are required to pursue cultural competency professional development yearly. They are trained in medical interpretation, Spanish terminology and other cultural aspects of health care. Districts have worked with various tribes, pueblos and Indian Hospitals to improve outreach, access to care and timely intervention for children with special health care needs (CYSHCN), and CMS leaders have attended conferences that address health issues specific to the African Americans to improve outreach.

In the Maternal and Child Health Collaborative, CMS works with UNM LEND, UNM Continuum of Care, Family Voices, Parents Reaching Out, Parents of Behaviorally Different Children, and Educating Parents of Indian Children with Special Health Care Needs to address cultural competence among other things. CMS' 60 statewide social workers serve and advocate for clients who may have difficulty accessing care for cultural or language reasons. Bilingual, community based care to CYSHCN clients is provided. At least sixty of the 120 staff are bilingual. /2008/The important role that bilingual staff play in the delivery of health to CYSHCN was recognized when the DOH approved additional payment compensation.//2008//

The Navajo Nation selected the NM Title V CYSHCN program as a partner in its Integrated Services for CYSHCN grant proposal. CMS will assist the Navajo Nation in developing a mentoring program for youth with special health care needs. /2008/At this time, the Navajo Nation is completing a needs assessment, and inclusion of the mentoring program will follow.

The Newborn Hearing (NBH) Coordinator will represent CMS at the National Center for Cultural Competence, Community of Learners Forum in Washington DC to advance and sustain cultural and linguistic competence in services and supports for CYSHCN. The Coordinator also is the chair of the CDC sponsored Early Hearing Detection and Intervention (EHDI) Diversity Committee a multi-agency, multi-state group whose goal is to address access to EHDI services for diverse families. The CYSHCN Program Manager and the Medical Director were invited to address the Native American Advisory Board to the DOH about services and systems available to CYSHCN. Region 2 staff is taking a lead in assuring Culturally and Linguistically Appropriate Services (CLAS) standard are practiced within Public Health programs by participating on a regional task

force.
In 2007, licensed social workers are required to complete 6 hours of continuing education in the area of cultural competence every 2 years, as per the new renewal period.//2008//
/2010/ The CMS Director and the NBH Coordinator presented a breakout session at CityMatCH on immigrant health in the fall of 2008.//2010//

C. Organizational Structure

The administration of Governor Bill Richardson consists of /2008/20//2008// State Departments, including the Department of Health.

The New Mexico Children's Cabinet was created by Executive Order and Governor Richardson appointed Lt. Governor Diane Denish, chairperson. She indicated that early childhood issues would be her top priority. Because the goals of the Maternal and Child Health Bureau/Early Childhood Comprehensive Systems (MCHB/ECCS) grant and Children's Cabinet were aligned, it was decided that the Lt. Governor would convene a group of early childhood stakeholders and experts to develop a comprehensive long term Early Childhood Agenda for New Mexico's young children and their families from birth to age 5. The role of this group is to implement the goals of the MCHB grant and to advise the Children's Cabinet. The Cabinet Secretaries from the Department of Health, Human Services Department, Children, Youth & Families, and the Aging and Long Term Care Departments also meet once a week to discuss issues that effect their departments and to address State Health and Human Services Initiatives. These four initiatives include the Statewide Comprehensive Health Plan, the Behavioral Health Plan, the Long Term Care Plan for Seniors & Individuals with Disabilities and the Medicaid System Redesign.

The new Secretary of the Department of Health, Michele Lujan-Grisham /2009/ Alfredo Vigil, MD//2009//is a Cabinet Secretary and reports directly to the Governor. The two Deputy Secretaries are Jessica Sutin, responsible for Programs and /2008/Duffy Rodriguez//2008//, responsible for Administrative functions.

/2008/A third secretary, Katrina Hotrum, was added to oversee facilities management of 5 hospitals and healthcare centers.//2008//

The Secretary's Office houses the Public Information Officer, Chief Medical Officer, Chief Information Officer and the Chief Privacy Officer (HIPAA and related functions), as well as the Office of General Counsel. The Deputy Secretary of Programs oversees three major divisions which include: Public Health Division, Developmental Disabilities Support Services Division, and Health Certification, Licensing & Oversight.

/2008/In 2007, the Office of Policy and Multicultural Health was added to the DOH. Its mission is to increase the capacity of the DOH, its contractors, and partners to reduce gaps in health status and improve the quality of life of the state's diverse populations.//2008//

The NM Department of Health (DOH) is a statewide agency organized into 5 Regions (formerly 4 that incorporated Bernalillo county into District I), and each of the 53 local health offices are a state agency entity. The DOH works to address issues in nine program areas that reflect budgetary funding sources. The nine program areas follow:

/2008/Note: There are now eight program areas.//2008//

Program Area 1, entitled Prevention and Health Promotion, houses the Family Health Bureau Programs, Infectious Disease Prevention and Treatment, Improving Health Initiative, and Chronic Disease Prevention and Control. Program Area 2 includes the Public Health District Offices and

Local Health Offices, the Office of Border Health Clinical Services, Rural Health Care/Primary Care Health Systems, the Office of School Health, and Dental Services.

/2008/Due to the change to 8 Program Areas, all of Public Health Division programs are now organized under Program Area 2, Public Health. The DOH is now organized into the following 8 Divisions: 1. Public Health Division, 2. Developmental Disabilities Supports Services Division, 3. Health Certification Licensing and Oversight, 4. Office of Policy and Multicultural Health. 5. Scientific Lab Division, 6. Epidemiology and Response Division, 7. Facilities Management, and 8. Administrative Services.//2008//

The Public Health Division (PHD) Director is Kristine Suozzi, PhD, /2009/Jack Callaghan, PhD //2009//The PHD Director's Office includes two Deputy Directors.

/2008/The Public Health Division (PHD) consists of 5 Region Offices, an Office of Border Health, a Pharmacy Office, and 5 Bureaus: Program Support, Health Systems, Chronic Disease, Infectious Disease, and Family Health. The Family Health Bureau is the largest bureau in the Public Health Division. The Family Health Bureau Chief position is currently vacant.//2008//

The Family Health Bureau (FHB) is located in the Colgate Building at 2040 South Pacheco, about six blocks from the main DOH building. Organizational charts for the Family Health Bureau and the Public Health Division of the Department of Health are in the Appendices./2009/ Maternal and Child Health is now managed by Carol Tyrrell. Emelda Martinez, the former Maternal and Child Health program manager, has taken the position of Family Health Bureau Chief. //2009// ***/2010/Dr. Alexis Avery is currently the acting program manager for the MCH Epidemiology section. Lynn Mundt retired as manager of the Family Planning Program in October of 2008, soon after, in November, State employees were placed on hiring freeze due to the economic status. Wanicha Burapa, Family Planning Medical Director is the acting Program Manager. Family Food and Nutrition (WIC) Program director Sid Golden retired in August of 2008, the acting program manager was Deanna Torres, who has since been named the Director for this position.//2010//***

/2008/ The FHB is organized into five programs: 1. MCH/Epidemiology, 2. Family Planning, 3. Children's Medical Services, 4. Family Food and Nutrition and, 5. Maternal and Child Health. FHB also maintains a senior Epidemiology consultant position. The senior Epedemiology consultant reports to the FHB Medical Director.

The FHB is responsible for carrying out all but two of the Title V programs.//2008// The Adolescent Health Program and the Child Safety Program are located within other DOH divisions.

/2008/The Adolescent Health Program is housed within the Health Systems Bureau in the Public Health Division (PHD.) Recently, the Bureau Chief of Health Systems became the supervisor of the Adolescent Health Program Manager.//2008//

The Child Safety Program has been located in the Injury Prevention and Emergency Services Bureau for several years. Recently moved to the Office of School Health, the Adolescent Health Program Manager reports directly to the PHD Deputy Division Director. The Division felt Adolescent Health belonged within that Office due the Governor's initiative to better fund the Office of School Health by providing 34 new school based health centers and to involve youth in policy making for those centers.

Those programs with allotments under the Title V Program are: Children's Medical Services for Children with Special Health Care Needs, the Maternal Health Program, the Child Health Program, the Child Safety Program, Adolescent Health and the MCH Epidemiology Program. Other partner programs administered within the same bureau are: the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC), the WIC Farmer's Market Nutrition Program, the Commodity Supplemental Food Program, the Title X Family Planning Program, the

state sponsored Families FIRST Perinatal Case Management Program, and the Title V Abstinence Education Program. /2009/The abstinence program is no longer funded therefore the program does not exist, however, abstinence is a part of the comprehensive system that continues to be taught in the Family Planning Program.//2009//

/2008/The PHD Director's office took responsibility for programmatic direction of the Abstinence Program, although fiscal processing still occurs within Family Health Bureau.//2008//

The Dental Program resides in the same building as the Family Health Bureau. The Dental Program continues to be in the Health Systems Bureau, with easy access to the FHB/Title V MCH Agency for consultations on oral health in mothers and children.

/2008/The Dental Program moved to the building that houses DOH administration.//2008//

The administration of Governor Richardson has benefited the Title V Program due to its focus on children's issues. Other streamlining has occurred within the Department as the new Secretary replaced all exempt positions with her own assignees. A SWOT analysis was completed and results were analyzed. Fortunately, some processes like travel have improved, while others have not with the administration. Personnel processes and contracting processes are still very inefficient although great effort has been exerted to try to shorten the processes. Recently, the administration announced a new plan whereby many administrative changes will take place based upon an analysis done of DOH by a private consultant.

Maternal, Child, Adolescent and Family Program (MCAF) The Child Health Program Manager's job duties are being revised to reflect a broader spectrum of activities in child health. The MCAF Section has absorbed the Families FIRST Program into its section. This state funded perinatal and child case management program will fit very well within the context of the MCAF Section and strengthen its ties to daily direct services.

/2008/The MCAF Section of Family Health Bureau was renamed Maternal Child Health (MCH) Section.//2008//

An MCH Epidemiologist is currently being added to the staff of MCAF to aid in the data collection and evaluation of MCH data, position funded by SSDI, to work on Title V MCH specific data and assessment tasks. This will include assistance with the development of state plan to assess childhood obesity and underweight; coordination of comprehensive assessments; the MCH Block Grant and analysis of WIC data for selected priority topics.

/2008/The MCH Epidemiologist was moved into the MCH Epidemiology Program of the Bureau.//2008//

The MCH Epidemiology Program in the Family Health Bureau has been modified to better serve the data and information needs of the FHB and its many partners. It has incorporated the resources that support data, surveillance and epidemiology for child health needs such as birth defects, newborn hearing screening. Analysis of the CYSHCN survey and NSCH is also performed within this group.

/2007/The organizational Structure of the FHB remains essentially the same, with the exception of the creation of a new senior level Epidemiologist who will report to the Medical Director and consult for the entire FHB. The senior level epidemiologist will advise the direction of data surveillance and policy impact and provide direct services requiring advanced methods. The Bureau is continually asked to provide advanced epidemiology consulting regarding policy for the Department and the Children's Cabinet. In addition, the Dental Program is moving to the building housing the DOH Administration.//2007// /2009/ The medical director and senior level Epidemiologist are now reporting directly to the Family Health Bureau chief.//2009//

FHB-PHD Organizational Changes Information Technology Consolidation: The Governor's Executive order to consolidate all information technology (IT) operations in State Government has greatly impacted IT and program operations All IT functions and staff were consolidated within cabinet and executive agencies and now report to the agency Chief Information Officer (CIO) of that agency. The Governor's Chief Information Officer control and manage of all IT expenses within the agency, either by the establishment of an independent IT organizational budget or by the establishment of administrative financial controls of IT expenses within existing agency budgets, subject to the approval of the Cabinet Secretary. The cabinet or executive agency CIO has approval authority over all agency IT-related spending, subject to the approval of the Cabinet Secretary. The cabinet or executive agency submits a complete inventory of agency IT hardware, software and licenses in a standardized electronic format, to the Office of the CIO by June 1rst. Telecommunication equipment and personnel were expressly exempted from this section and this Order. Exceptions are made for purchases that are critical to DOH. The full impact of this order on services and operations remains to be seen. The Help Desk, once operated by the FHB on behalf of the entire Department has now been moved out of the Colgate Building and resides in the Runnels Building. Help Desk calls have been greatly reduced as staff in local offices feel that it is not as responsive as it should be. The e-mail system changed at the end of May to using Outlook.

/2008/The Department has adjusted to using the new e-mail system. However, a new financial system was implemented in 2008 which serves all of New Mexico State Government. The impact of implementing the large project over a short period of time greatly decreased the effectiveness of State staff. Training was insufficient for users and there are not user manuals specific to the DOH application. Financial reports are a challenge to produce and there is no summary report for encumbrances by line item yet.//2008//

/2009/Difficulties continue with the financial accounting system. There have been steps to assist in training needs. The Family Health Bureau (FHB) has implemented a fiscal group designed for senior fiscal staff to assist those that may be experiencing difficulty. This has proven effective. FHB also scheduled a managers training session to assist managers with the financial system, how to obtain reports, view balances, etc. This was well received and a follow up session was requested.//2009//.

D. Other MCH Capacity

D1. Office of the Family Health Bureau Chief

/2007/The Family Health Bureau houses 10 separate programs. The Bureau Chief, the Medical Director and program support staff work collaboratively as a team to use resources strategically to meet identified needs within this population depending on program focus. Bureau Chief, Jane Peacock, M.S., R.D., provides leadership and direction for Bureau staff to engage in core public health functions and provide essential public health services in the context of the Title V Grant and the Department of Health (DOH) Strategic Plan. She has served as Title V Director since December 2002. She has extensive public health management experience, served for 15 years as State WIC Director, and also has private administrative and clinical hospital experience as a registered dietitian. Ms. Peacock serves as Department liaison for the Lt. Governor's Children's Cabinet, in the absence of the Secretary of Health as well as designated State Nutrition Director for DOH.//2007//

/2008/Ms. Peacock left FHB to become the new Deputy Director for the Public Health Division on July 1, 200t.//2008//

/2009/Emelda M. Martinez is the new Bureau Chief. Ms Martinez has extensive MCH management and experience. As an RN she worked in the Pediatric Intensive Care Unit at St. Vincent's Hospital for 10 years. She worked with Human Services in the Medicaid Division

managing the Maternal, Family Planning, EPSDT and Midwifery programs. She has worked with the Department of Health for 5 years managing the Families FIRST case management program and Maternal and Child Health.//2009//

/2007/Dr. Margaret Gallaher serves as the Title V Medical Director. A board certified pediatrician with a Master's in Public Health, she has served as Medical Director of the CYSHCN Program in New Mexico. Her Masters work involved early intervention for young children with developmental disabilities and she has conducted research on children with autism. She has had many years of experience working with children with developmental difficulties and has consulted for other physicians in both hospitals and outlying clinics regarding pediatric clinical services in New Mexico. She is also a valuable background in epidemiology.//2007//

/2009/Dr. Elizabeth Matthews is the Title V Medical Director. She is a board certified pediatrician, and served as Medical Director for CYSHCN in New Mexico for the last 4 years. and as a pediatrician served CYSHCN for fourteen years at the University of New Mexico.//2009//

/2008/Dr. Gallaher is now the Medical Director for the Public Health Division later this year.//2008//

/2008/Dr. Susan Nalder supports FHB through her position as senior MCH Epidemiologist in the office of the FHB Medical Director providing assistance to the Children's Cabinet and other special projects for FHB, PHD, other agencies, and organizations. She functions as a policy analyst to support legislative bill proposals, and is leading the effort to link and analyze WIC data for areas such as immunization and early childhood growth.//2008//

/2007/The Bureau administrative staff consists of Monica Montoya, Financial Administrator and Andy Gonzales, Clerk Specialist, who provide overall Bureau program support. The Bureau also supports a Systems Analyst who reports directly to the Information Technology Bureau, yet supports the IT needs of Title V staff.//2007//

/2009/Jolene Deras is the Clerk Specialist.//2009//***/2010/Amanda Sandoval replaced Jolene Deras as Clerk Specialist//2010//***

D2. Children's Medical Services

There are 114 staff in 32 field offices throughout the state along with 14 state office staff. All staff work on Title V CYSHCN programs.

/2010/ The state office is down two crucial positions, the Health Educator in charge of NMMIP/Youth Transition and the Clinic Coordinator. The field staff are also down critical positions including the Program Manger for Region 5, 2 clerks, 7-social work positions. The CMS program is unable to hire at this time due to the statewide hiring freeze.//2010//.

/2008/A new CMS FIT position was created in Region 5, located in Anthony in the Southern part of the state. A new CMS FIT position is in the process of being created in Region 2 to address unmet needs in the Northern part of the state.//2008//

The state office staff consists of the Title V statewide CYSHCN program manager, the medical director, two nurse consultants who work with newborn screening with one nurse position receiving funding from the state lab, and a Family Infant Toddler Coordinator who is funded through a JPA with the Long Term Service Division of DOH to link the Title V program with the statewide early intervention program, a clinic coordinator, financial specialist, office administrator, a health educator and clerical staff. A position is being created for a Newborn Hearing Screening Coordinator, having just received a three-year HRSA/MCH grant award. The CMS management team includes the statewide Title V CYSHCN program manager, the medical director, the field supervisors, program managers and key state office staff. The management team meets monthly

to review policy issues related to the implementation of the CMS programs.

/2010/Dr. Janis Gonzales was hired in 2008 as the new CMS Medical Director. Dr. Elizabeth Matthews, the previous CMS Medical Director, was promoted to Family Health Bureau Medical Director.//2010//

/2008/The FIT Coordinator moved into the Newborn Hearing Screening Coordinator position. This is an integrated position in the Title V CYSHCN Program, and her duties include assistant to the Title V CYSHCN Director, thus assuring integration of program efforts. A new FIT Coordinator was hired.//2008//

The Birth Defects Prevention and Surveillance System grant from CDC ended. A grant proposal to continue the Birth Defects Registry was approved without funding. Working within the program are at least two parents who have children with special health care needs, and others who were children/youth with special health care needs or had sisters or brothers with special needs. In addition, the Title V CYSHCN program contracts with Educating Parents of Indian Children/2007/and Parents Reaching Out (PRO)/2007// to provide support and training of parents. In this way, the program has internal and external family expertise.

/2008/Contracts continue with EPICS to provide training to CMS staff on cultural competence related to serving the Native community. The CMS CYSHCN management team participates in the planning and evaluation of the delivery of services to CYSHCN. With a Statewide Program Manager who is a social worker and four District Program Managers who are social workers, as well as 12 Social Work Supervisors, the 52 social workers in the CYSHCN program receive ongoing supervision and evaluation of their job performance. A FIT Coordinator is a statewide consultant/supervisor assisting district supervisors in assuring federal statute compliance and job performance evaluation.

The CMS program has begun to work in collaboration with the Family Health Bureau MCH Epidemiology program to improve it's data collection and analysis of the newborn hearing screening program and other health indicators especially as reported in the 2001 SLAITS survey. Supervisors evaluate their services in an ongoing fashion, with a computer program that assists them in monitoring caseload size. /2008/The CMS program is collaborating with Families First, Newborn Screening and Birth Defects to purchase a case management and data collection web-based system to improve its ability to analyze the programs.//2008// ***/2010/ The case management and data collection system was implemented and is being utilized by the Newborn Screening and Birth Defects programs.//2010//***

D3. Maternal Child Health, Title V Funded Staff:

/2008/Emelda M. Martinez, RN, is Section Manager and supervisor of five programs, four programs funded by Title V and one revenue driven program This includes seven State office staff. Roberta Moore, ASN, CNM, is the Maternal Health Manager, responsible for the High Risk Prenatal program, Midwife Licensure and Regulation and the Maternal Health program. The Child Health Manager, Sarah Flores-Sievers, is responsible for the ECCS Grant, Las Cruces Home visiting contract, and program activities that focus on children. She has taken a position in the WIC office, and her position with MCH is currently vacant. Health Educator, Gloria Bonner assists with segments of the ECCS grant and the child health component of the program. Clerk, Edna Campos, Specialist, provides office support for MCH staff. Administrator II, Rima Varela, performs budget operation processes for MCH program and Families FIRST program manager Maureen Burns.

/2009/Staff changes: Carol J. Tyrrell, RN, is the MCH manager; Gloria Bonner is Child Health Program Manager; Diane Dennedy-Frank is Maternal Child Health Educator; Amanda Romero is the new clerk//2009//

The Families FIRST Program is a revenue driven program obtaining reimbursements negotiated through Managed Care Organization (MCO) contracts and Medicaid (JPA). Maureen Burns, Program Manager supervises five state staff, providing oversight of four Regional Coordinators and 38 Care Coordinators. Social Worker Consultant currently vacant, develops needs assessments; training to address needs and improve services to clients, and quality assurance. Marilyn Pearson, Registered Nurse Consultant, provides programmatic direction to four Regional Coordinators. She also monitors the Families FIRST Provider network, and provides oversight of quality improvement for the perinatal case management population. Care Coordinators provide care coordination for pregnant women and children, assist clients with Presumptive Eligibility/Medicaid On Site Application Assistance (PE/MOSAA) and the MCO process. They also assist with establishing medical homes, community resources and referral networks. Families FIRST Care Coordinators are located in 22 counties throughout the state. Lorraine De Vargas, Management Analyst, maintains financial processes, and budget operations. Jessica Marquez, Medical Secretary, maintains client and claim-processing databases. A vacant position, the Financial Specialist, manages claims processes. Ruth Gonzales, Clerk Specialist, provides support for Families FIRST staff. She retired in June 2007, and her position is currently vacant.//2008//

/2009/Staff changes: Clerk Specialist, Carmen Herrera. Social Worker + Financial Specialist position currently vacant.//2009// ***/2010/ The MCH Health Educator and Clerk positions were filled this year with Diane Dennedy-Frank, MSW, LISW, and Amanda Romero respectively. All other staff remain the same. //2010//***

D4. MCH Epidemiology

/2007/Saumitra SenGupta, PhD, MS, began as Program Manager in April 2006; he supervises 6 positions, and 3-5 contractors. Additional responsibilities include directing the SSDI project, overseeing the Title V MCH needs assessment, data analysis and reporting, overseeing the PRAMS project implementation. Special projects include evaluation of Families FIRST and renewal of NM Maternal Mortality Review.

/2008/Mary Overpeck, DrPH, replaced Dr. SenGupta as MCH Epidemiology Program Manager on November 6, 2007. The evaluation of Families First and renewal of NM Maternal Mortality Review have been delayed but other responsibilities will continue. Dr. Overpeck was collaborating with FHB on a project to integrate family violence prevention into the MCH programs prior to her transfer from management of the NM Office of Injury Prevention. This project and other child and family injury collaborations will continue.//2008//

/2009/Dr. Overpeck retired in March, 2008. Dr. Alexis Avery is acting manager of MCH Epi.//2009//

2.Mary Shepherd, PhD, MS, Senior MCH epidemiologist and lead analyst for PRAMS; special projects may include analysis of linked WIC+PRAMS or other linked data sets; provides Technical Assistance (TA) to MCH epidemiologists; consults to many programs; position funded by Title V MCH.

/2008/Mary Shepherd became a member of the research faculty at the Johns Hopkins University Center for American Indian Affairs in March, 2007. Jennifer Hudson, MPH, Epidemologist/PRAMS Analyst, joined MCH EPI on April 21, 2007 to replace Dr. Shepherd. The duties will remain the same with an increased emphasis on completing SSDI linkage projects and using her strong skills in GIS.//2008//

3. Eirian Coronado, MA (anthropology): NM PRAMS Coordinator-Epidemiologist. Key tasks in data to action, PRAMS implementation, coordination of NM PRAMS with CDC, NM DOH and partners; funded by CDC PRAMS Cooperative Agreement.

4. Dorin Sisneros, NM PRAMS Survey Operations Manager, is responsible for data collection for NM PRAMS; funded by Title V MCH Block Grant.

5. Denise Wheeler, MA: Title V MCH epidemiologist and coordinator;

/2008/Alexis Avery, MPH, became Title V MCH epidemiologist and coordinator on March 24, 2007. In addition to the MCH Title V coordination, she will perform evaluation work in collaboration with MCH Title V programs.//2008//

6. Mary Baca, Clerk Specialist. Provides full-spectrum of administrative and clerical support including PRAMS tasks. Funded 25% Title V MCH and 75% PRAMS Cooperative Agreement.

/2008/Mary Baca left February 9, 2007. Rebecca Garcia became the Clerk Specialist on April 21, 2007. She is funded 50% from Title V MCH for administrative and clerical support and 50% from the PRAMS project to provide operations support for the survey.//2008//

7. Management analyst: pending funding, to provide database management services to Maternal Mortality, newborn screening, related projects.

*Fellows and interns: none at present; will seek as appropriate. /2009/CDC/GSIP Intern to join 6/16-9/16, 2008//2009//

*Partial funds for salary are generated through a JPA with Medicaid for PRAMS, based on Title V MCH state general fund portion of positions working on PRAMS.//2007//

/2008/FHB continues to seek funding to support this position. MCH Epidemiology has applied to incorporate intern opportunities.//2008//

/2010/Jacob Smith, HRSA graduate student intern, worked with MCH Epi in summer, 2008//2010//

D.5 The Family Planning Program (FPP):

There are 70 staff in 32 ***/2010/ 48 staff in 23 //2010//*** field offices throughout the state along with 16 ***/2010/8//2010//*** state office staff. All staff work on Family Planning. The field office staff consisting of nurses, clinical nurse practitioners, and clerks provide direct services to clients within their communities and function within the public health structure. The state office staff consists of the Family Planning program manager, /2008/Lynn Mundt,//2008// who supervises all Program staff, oversees the FPP operations in local health offices and contracting agencies, prepares and monitors budgets and agency grants. There is also a vacant assistant staff manager, who would oversee the day-to-day operations of the administrative activities of the Program.

The Medical Director, /2008/Wanicha Coggins, //2008// ***/2010/ Wanicha Burapa //2010//***reviews and updates clinical protocols. She also serves as a liaison for clinical services with the FHB Medical Director and Clinicians Group, STD Program, Breast & Cervical Cancer Program and Clinical Prevention Initiatives. She also provides technical assistance in planning, evaluation and data analysis for the Program.

There are three nurse consultants, one of which is vacant, who update clinical protocols, serve as liaisons for clinical services with the Nurse Practitioners and Clinicians group, and coordinate laboratory and Pharmacy services provided in the local health offices. Nurse consultants coordinate and perform clinic site reviews. They serve as liaisons with the Directors of Nursing Services and Nurse Managers. Additionally, they oversee the Sterilization Program, client, and monitor clinical contracts.

There are four health educators, two of which are vacant, who oversee the Male Involvement and Community Education program activities the FPP Advisory Committee and FPP website contract. Other duties include overseeing the Adolescent Pregnancy Prevention program activities, managing educational contracts, including monitoring and evaluation, and editing and publishing the FPP newsletter. They had, until recently, coordinated all training activities and produced a training plan. Although the training assignments have decreased they continue to update the training resource library and monitor training contracts.

The two contract officers ***/2010/planners//2010//*** are responsible for establishing FPP contracts and provider agreements. The financial specialist, clerk, and vacant financial office administrator, are responsible for the program personnel ***/2010/sterilization reimbursements//2010//***and budgetary services and general clerical services for program. There is a vacant staff development specialist ***/2010/fee collection liaison//2010//*** who would oversee the Program's client data system services. The management analyst creates forms and databases; collects and analyzes annual surveys.

Currently six /2009/seven//2009// positions are vacant. ***/2010/There are 2 Nurse Consultant and 3 Health Educator positions. FPP newsletter is not published due to staffing shortages. Training activities are now done by the FPP as a team. Fee Collection Liaison and Administrator positions are filled. Vacancies are: Program Manager, one Health Educator, Staff Manager, Management Analyst, one Planner, Financial Specialist & Clerk.//2010//***

E. State Agency Coordination

E 1. Organizational Relationships among the states human service agencies:

/2007/The Families FIRST program provides case management services//2007// in 22 counties, contracting with the Managed Care Organizations (MCOs) provider network and public health offices to address the needs of pregnant women and children 0 to 3 years of age. Efforts have been made to increase Medicaid reimbursement rates and provide uniform services.

/2007/DOH has begun Medicaid administrative billing across programs with the assistance of a contractor. Currently services may differ from MCO to MCO and from MCO to Medicaid fee for service. //2007// Both MCH and Families FIRST are involved in the EPSDT Steering Committee.

/2008/Title V Section 510 (b(2) provides funding to enable the state of New Mexico to make available abstinence education, and, where appropriate, mentoring, counseling, and adult supervision to promote abstinence from sexual activity. The Department of Health, Family Health Bureau contracted with eight community-based programs to provide curriculum-based abstinence education to students in grades 6 and under during in-school hours. Additionally, after-school and summer programming was offered to students in middle school and high school. To raise statewide awareness of abstinence education, a media campaign was implemented. Approximately 8,000 students, parents and community members participated in abstinence education programming for FY 2006. A program evaluation was conducted by the University of New Mexico Health Evaluation and Research Office. The Abstinence Education Program cooperated and collaborated with the Family Planning Program, PRAMS, and the Office of School Health on teen pregnancy prevention issues within the Family Health Bureau.//2008//

/2010/In FFY 2006 the New Mexico Department of Health was denied funding for abstinence education. Subsequently, the department chose not to apply for additional funds.//2010//

/2007/Both CMS and Families FIRST work in close collaboration with all of the state's Human Services Agencies.//2007// Each program assists clients in applying for Medicaid and S-CHIP through the Medicaid On Site Application Assistance (MOSAA) and Presumptive Eligibility

applications, and coordinates with the local Income Support Division (ISD) offices to assure quality client service. ***/2010/ Families FIRST case managers are now able to enter PEMOSAA information directly into the State's Human Services Division online system for children 0 to 3 years of age.//2010//***

/2008/CMS assesses insurance options for clients. Social workers assure that CYSHCN do not temporarily lose Medicaid benefits due to Deficit Reduction Act (DRA) requirements for proving citizenship. Some children have been losing their Medicaid benefit because of the new requirement to verify citizenship. The FIT program now requires mandatory screening for insurance on all clients enrolled in the program. Additional FIT providers are being trained in PE/MOSAA.//2008//

The CMS-FIT staff has begun to work closely with Children Youth and Families (CYFD) to implement the requirements of the federal Child Abuse Prevention and Treatment Act (CAPTA) legislation where children birth to three years of age with a substantiated case of abuse and neglect must be referred to early intervention. The Healthy Transition New Mexico Coordinating Council is an interagency group including the Division of Vocational Rehab (DVR), Medicaid, and Medicaid MCO/Salud! Programs, CMS, UNM Continuum of Care, the LEND Program, UNM Family and Community Partnerships Division of Center for Developmental Disabilities, Parents Reaching Out, EPICS, and Family Voices. The CMS Title V CYSHCN statewide program manager was appointed by the Governor to the Interagency Coordinating Council (ICC). This is the advisory body to the FIT program. The Council is made up of representatives from Medicaid, CYFD, Public Education Department, Public Insurance Commission, the medical society, local early intervention providers, UNM and families.

The MCH Collaborative and the Enchanted Rainbow in which CMS is a member, meet quarterly to address statewide issues related to CYSHCN in collaboration with Medicaid and the Medicaid MCO/Salud! programs and other partners.

/2008/Enchanted Rainbow has stopped meeting due to a lack of funding and leadership. There had been improved attendance by the Managed Care Organizations (MCOs). The Regional office in Region 1 and 3 arranged for a presentation by 2 of the MCOs on working with their CYSHCN case managers which did help improve communication between programs. CMS is represented on the Family to Family Health Advisory Board with PRO, the MCOs and Medicaid. The Newborn Hearing (NBH) Coordinator participates on the Deaf/Hard of Hearing (D/HH) Task force at New Mexico School for the Deaf (NMSD) to address unmet needs of D/HH children in their communities. Task force members include NMSD, parents, Commission for D/HH, The Public Education Department (PED), and local school disticts.//2008//

The Title V Director is a member of the Early Childhood Comprehensive Services Advisory Board. Providing services and multidisciplinary clinics statewide, the CMS Program connects with over 900 medical providers and all community social service agencies and state agencies.

/2007/With the Governors' Insure New Mexico Initiative, coverage is being expanded regarding 0-5 programs and youth above age 19 programs for Medicaid-like program for non-Medicaid children and youth. In addition, a new program called the State Coverage Initiative Program was instituted in FY05 for employers with less than 50 employees. This program requires a minimal payment by both the employer and the employee and provides comprehensive health coverage. Rules for the new non-Medicaid children's insurance programs are being written. The CMS leadership is involved in the discussion of rule setting. These programs will likely overlap the CMS CYSCHN and Healthier Kids Fund (HKF) programs.//2007//

/2008/The expanded coverage did not include CMS CYSHCN and HKF. CMS has been a participant in the Medicaid Outreach Committee however which is actively working to enroll children onto the various Medicaid programs. There are several gaps in coverage in several of the new Medicaid programs including lack of coverage for dental, vision and mental health

services.//2008//

/2009/CMS participates in quarterly meetings with HSD, the Saluds and Value Options to assist with outreach efforts for the various No Cost/Low Cost Insurance plans offered through HSD. The meetings focus on outreach and enrollment efforts which now include coverage for pregnant women, children birth-18 and small business and non-profits.//2009// ***/2010/ The CMS Medical Director participates on the Multi-Agency Task Force on Early Childhood services and the NM Influenza Vaccine Coalition to assure influenza vaccine availability for CYSHCN.//2010//***

The CMS FIT program receives funding from the Long Term Services Division and the Coordinator provides training for FIT staff and early intervention programs regarding provision of service coordination and federal statute compliance.

/2007/The CMS FIT federal funding for the CMS FIT coordinator position was cut in half for FY07.//2007// /2009/ the federal funding for the entire CMS FIT program was eliminated//2009//

/2008/CMS Title V CYSHCN Director is appointed by the Governor to participate in the Interagency Coordinating Council for children served by the Family Infant Toddler Program. This council includes Children Youth and Family Department, Human Services Department, Public Education Department, Department of Health Developmental Disabilities Supports Division, parents, parent organizations, and early intervention providers. These connections also accrue to the CYSHCN Program.//2008//

The New Mexico Department of Health was awarded a grant from the Health Resources Services Administration (HRSA) to develop an infrastructure to implement a NM Oral Health Surveillance System (OHSS). In partnership with the Health Systems Bureau and District II Santa Fe CMS program, the statewide Oral Health Surveillance System (OHSS) pilot program is providing case management to over 300 clients through a part time social worker. The OHSS collects, measures and assesses oral health conditions and disparities in women, children and families. It also improves access to preventative and restorative services. Collaboration continues with numerous agencies, programs, and dental offices within the community. There has been significant success in promoting oral health care with our participation in community outreach events such as local health fairs, Sealant Clinics, and the CMS Cleft Palate Clinics. People are utilizing the services of the dental case manager and appear eager to learn more about proper dental care for themselves and their children. Case management has been beneficial in helping clients follow through with appointments, accessing oral health care resources (including financial), and providing important educational information about oral health care maintenance. By improving access to oral health care through case management, the expected outcome is to reduce dental caries in children and establish an effective oral health screening and referral service for children and their families.

/2008/A dental case manager was hired by DOH as a result of a HRSA award to New Mexico. The goal of this pilot project is to employ a dental case manager to improve access to oral health care and to reduce dental cavities in children 12 years of age and under. Through the Dental Sealant Program 216 children received case management services during 2005-2006. The Head Start Fluoride Varnish Program served 100 children and parents/care givers received oral health education training. Over 110 children received dental screening, fluoride varnish application and follow up care through the case management program. Each parent/caregiver received oral health education training, through the WIC program. Child Find/Special Education served 80 children with dental screening and oral health education. The children also received dental case management services. CMS Program served 291 walk-in or call-in children and adults who received dental case management services during 2004-2006. Since the federal funds will be terminating in August 2007 DOH is re-classifying a vacant position to establish the dental case manager on a permanent basis. Outreach to the Northern Pueblos in Santa Fe County was done and included education provided to the Tesuque Pueblo Head Start, and Nambe Pueblo Head Start.//2008//

/2009/ The Dental program continues to help individuals and families access dental services in the community through Dental Case Management in Santa Fe only. ***/2010/ Rio Arriba County now has 1.5 FTE's as well.//2010//***This program has been very successful and the DOH PHD is looking to replicate it statewide. The program also provides oral health and educational outreach in the community, including Head Start Programs and childfind screening clinics (SF and Espanola area), oral health education and dental case management/follow-up with the Fluoride Varnish Program (for children 0-5 years of age), coordination of these clinics in partnership with SF WIC, SF and Rio Arriba Headstart programs. It participates with the Office of Oral Health's Santa Fe Public School Sealant Activities (for children in the first through third grades) in provision of oral health education and dental case management/follow-up. The program coordinates free adults dental clinics throughout Region II in partnership with the Community Dental Services and provides consultation to Region II Public Health Programs to provide enhancement of dental case management to PH clientele.//2009// ***/2010/ Now in Rio Arriba County as well. The program now has 1.5 FTE's.//2010//***

E.2 Relationship of the state with selected entities:

Federally qualified health centers and primary care association(s): At the state level, the Community Health Systems Bureau oversees the primary care program, administering grants of state money and regularly communicating with each center and association, as well as the New Mexico Primary Care Association. FHB managers are meeting on an ongoing basis with the leadership of the Health Systems Bureau to study access to prenatal care statewide and to strategize how to increase access. University of New Mexico (UNM): DOH prenatal care clinics all refer high-risk patients to primary care or private providers, or UNM Health Sciences Center (HSC). All of these are under agreements with the Maternal Health Program to provide appropriate high risk care. UNM HSC is also under contract to provide low-risk care to 431 medically indigent Albuquerque residents. Maternal Health collaborates with UNM HSC to improve safety-net prenatal services statewide. Tertiary care facilities: Tertiary Care Facilities are so determined by specialty services and capacity. In NM there are two "level III perinatal facilities" with maternal-fetal specialists, neonatal specialists, and facilities to provide specialty care. These are: University of New Mexico Hospital and Presbyterian Hospital, both located in Albuquerque. They have a joint transport system to transport women in pre-term labor from around the state. The DOH assists in training of UNM School of Medicine students and residents in their rotations through selected DOH clinics. Both hospitals provide specialists and sub-specialists for the DOH Children's Medical Services (CMS) cleft palate outreach clinics throughout the state. UNMH provides pediatric specialist providers in collaboration with CMS to provide 128 pediatric specialty outreach clinics a year around the state. Clinics provided include asthma, cleft palate, neurology, metabolic, endocrine, genetics and nephrology. UNMH pediatric sub specialists in metabolism and genetics are contracted to consult with the State Laboratory and CMS on CMS's Newborn Genetic Screening Follow-up Program.

/2009/ CMS and UNMH are in the process of negotiating an increase in the number of outreach clinics. This is limited by the shortage of pediatric specialists in the state. To address the issue-of limited pulmonologists at UNM and in New Mexico, the CMS CYSHCN Program together with DOH Epidemiology have initiated a statewide effort to hold Asthma Summits regionally. The summit is addressing regional needs and will develop local and state alternative responses and interventions. An example would be: increasing the knowledge and participation of school health nurses and improving the communication between the school health nurse and the PCP in the child/youths medical home.//2009//

/2008/CMS contracts with Oregon State Public Health Lab to provide screening for the expanded program in coordination with the CMS Medical Director, Nurse Manager and the nurse case manager, who work with OSPHL to assure short and long term follow-up on infants with a presumptive or confirmed positive. CMS contracts with UNM metabolic and genetic specialists to provide state expertise and care post-diagnosis.//2008//

UNMH provides the PALS physician hotline, which provides immediate specialty consultation to physicians in the DOH and other state agencies. Specialty Departments at UNMH and other UNMH facilities provide information, consultation and collaboration on various DOH and other state projects. CMS cares for children with complex medical problems and these children often require care at a tertiary care center or by tertiary care specialty clinics. Training Programs and University Programs: the UNM Maternal Fetal Health Department provides training for staff at rural hospitals around the state and conducts 12 outreach clinics per month throughout the state. They provide recognition management and transport for premature labor. A toll free consultation line was established for local providers throughout the state 24 hours a day 7 days a week. Family organizations: Children's Medical Services contracts with Educating Parents of Indian Children (EPICs) to provide support and training of parents. The CMS Program receives consultation and training from Parents Reaching Out and EPICS.

/2008/The program has been working with a newly formed parent organization, a chapter of Hands and Voices to support families with children who are deaf or hard of hearing. This program sponsored participation at the national EHDI conference for one of the parents. One of the members is now serving on the CMS NBHS advisory council. //2008//

/2009/ The CMS NBHS Coordinator was asked to become a Board Member for Hands and Voices//2009//

In addition, working within the program are at least two parents who have children with special health care needs, and others who were children/youth with special health care needs or had sisters or brothers with special needs. In this way, the program has internal and external family expertise. All organizations and family members internally and externally provide consultation regarding MCH initiatives and program policy. The program has experienced difficulty in contracting with family organizations due to recent ongoing revision of the contracting process within the Division.

/2009/ CMS is contracting with EPICS (Education of Parents of Indian Children with Special Needs) to provide leadership training to parents who have CYSHCN and will be participating in the integrated services Dine for Our Children DOC Project with the Navajo Nation with a focus on youth transition.//2009//

/2008/Maternal Health Program has met with the Education and Training Coordinator of the County Health Councils Program, part of the Community Health Systems Bureau to discuss strategies to enhance flow of information and activity between the Family Health Bureau programs and the community-based County and Tribal Health Councils. 32 of the 33 counties and 5 tribal entities have such Health Councils, with memberships representative of their counties and with the missions of coordinating health coverage, decreasing overlaps and gaps, assessing needs and planning around two mutually agreed focal health goals in each Council. The plan is to present program local and state resources, goals and needs at the Health Councils' twice-annual statewide meeting this fall.//2008//

/2010/Child Health Program applied for and was awarded the SAMHSA grant, Project LAUNCH (Linking Actions for Unmet Needs in Children's Health), in 2008. LAUNCH promotes wellness of young children, creating a shared vision that drives the development of networks for the coordination of key child-serving systems and the integration of behavior and physical health services. Working in cooperation with ECCS and Project LAUNCH, a state-wide early childhood comprehensive systems strategic plan is being developed that is broad enough to guide all of the early childhood system's building work in New Mexico, irrespective of multiple funding streams.//2010//

/2010/Maternal Health Program conducted a survey of the County Health Councils' peri-natal care resources. The focus was on Medicaid clients, Medicaid ineligible women, teen

pregnancies, incarcerated women, and Native American women. The information was used to identify barriers to obtaining peri-natal services, including counties with no providers. A map and summary were developed that included the number of providers for each county, including OB/GYNs, MDs, certified nurse midwives, and licensed midwives, as well as 8 county public health offices that provide prenatal care to low risk clients. //2010//

E.3 Coordination of the Title V MCH Program with specific MCH-related programs:

/2007/MCH has a long history of leadership that promotes work on behalf of children and families. The MCH Program Manager is a member of the statewide EPSDT Steering Committee. This committee is charged to discuss methods and alternatives that would be used to improve the number and quality of EPSDT screens. Preventive health guidelines are based on recommendations from the American Academy of Pediatrics. /2009/ The Maternal Health Program works to maximize maternal, infant and family health by increasing access to quality prenatal care and other pregnancy-related health care services. Through support of direct services, assessment and policy functions, Maternal Health Program, focuses on pregnant women and their families. The Maternal Health Program licenses and regulates both certified nurse-midwives (CNM) and licensed midwives (LM) for New Mexico. According to the State Center for Health Statistics' NM Selected Health Statistics Annual Report 2004, CNM's and LM's attended 7,890 (27.8%) of the 28,355 births in New Mexico in 2004, primarily in hospital settings, but a few in homes and birthing centers. Prenatal, postpartum, gynecologic and well-woman primary care was also provided. A survey that is part of their re-licensure application reports that averages of 65% of their clients are on public assistance for their care. Of the 94 licensed midwives, 60 are now residing in New Mexico. //2009//

The Families FIRST (FF) Perinatal Case Management program provides perinatal case management to pregnant women and children ages 0-3 years. FF is reimbursed for services by Medicaid and contracted MCOs.

The Title X Family Planning Program (FPP) part of the Family Health Bureau, funded in part by Title V MCH. The FPP has three objectives: 1) to reduce teen pregnancy among girls 15 -17 years to a rate of no more than 50 per 1000 by the year 2006. 2) To reduce to no more than 45% the proportion of all pregnancies that are unintended in females 13-44 by 2006 and 3) To reduce the prevalence of Chlamydia trachomatis among young women under the age of 25 to no more than 5%. Family planning activities are collaborative between federal, regional, state, local, and non-profit organizations. Focus projects include the Family Planning 1115 Medicaid Waiver; adolescent pregnancy prevention; male involvement; sexual coercion prevention; sterilization; quality assurance; clinic management; data management/fee collection; and screening for Violence, Alcohol, Substance abuse, and Tobacco use (V.A.S.T.). Family planning clinical services are provided throughout the state in 53 Local Public Health Offices and 75 contracted service sites. Through the Healthier Kids Funds the FPP has contractors statewide to provide clinical family planning, pregnancy testing, counseling and STD services to adolescents. The New Mexico Teen Pregnancy Coalition (NMTPC) "Challenge 2005: Reducing Teen Pregnancy in New Mexico" initiative had positive results: 14 counties met the challenge of reducing teen births by 20%.

/2009/Family planning activities are collaborative between federal, regional, state, local, and non-profit organizations. Focus projects include the Family Planning 1115 Medicaid Waiver; adolescent pregnancy prevention; male involvement; sexual coercion prevention; sterilization; quality assurance; clinic management; data management/fee collection; and screening for Violence, Alcohol, Substance abuse, and Tobacco use (V.A.S.T.). Family planning clinical services are provided throughout the state in 50 Local Public Health Offices and 79 contracted service sites. Through the Healthier Kids Funds the FPP has contractors statewide to provide clinical family planning, pregnancy testing, counseling and STD services to adolescents.

Challenge 2010, a project of the FPP and the New Mexico Teen Pregnancy Coalition, asks counties to reduce teen births by 15% from 2006-2010. In 2007, the second year of Challenge 2010, 5 counties reduced birth rates to 15-17 year olds by at least 6%: The 2007 Challenge pamphlet focused on youth development strategies that positively affect teen pregnancy prevention.//2009//

WIC Program: The Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) Program safeguards the health of pregnant, breastfeeding and postpartum women, infants and children under five years of age with a household income 185% of FPL who are at nutritional risk. Currently USDA has provided New Mexico funding to serve 58,775 participants per month. The WIC Program was the first in the nation to pilot a hybrid electronic benefits transfer card for WIC recipients using a cost effective model. WIC and the CMS FIT program developed a plan to increase referrals of children with special health care needs and children with or at risk for developmental delay.

Commodity Supplemental Food: This program provides supplemental nutritious food to low-income women, infants, children and seniors. USDA donates the food. New Mexico is one of the top three states in the country for food insecurity. NM has applied for more caseload from USDA and has not been granted new caseload for several years.

Farmers Market Nutrition Programs (FMNP): This program provides fresh fruits and vegetables from farmers' markets to women, infants, and children who are nutritionally at risk and who are participating in the WIC Program. Participants receive $20 in coupons to be redeemed at local Farmers' Markets.

/2010/The WIC food package is being revised to include a greater variety of healthy food choices that are culturally acceptable. The WIC foods provided to families are specially designed to provide specific nutrients to help with the growth and development. WIC Program received a $390,000 grant from USDA to reduce childhood obesity. USDA has provided New Mexico funding to serve 67,000 participants per month.//2010//

The Title V Director works with the State Early Childhood Comprehensive Systems (SECCS) network, steering committee, and Children's Cabinet to promote the concept of preschool for 4 year olds as well as early learning objectives.

/2008/The Office of Injury Prevention (OIP) of the Dept. of Health takes the lead on all aspects of unintentional childhood injury and has had a contract with SAFE KIDS Worldwide to be the sponsor for NM SAFE KIDS Coalition for the past 15 years. OIP and its partners provide car seat clinics, including free car seat checks and/or seat replacement, bicycle rodeos, including free helmet fitting checks and/or distribution, and health fair displays, including free smoke and carbon monoxide detector, as well as gun lock, distribution. OIP has also collaborated with the Children, Youth and Families Dept. during the past 5 years to provide home safety training for the 8,000 home daycare providers, and plans to expand the program to foster, adoptive and grandparents.

State coalition members were instrumental in the expansion of the child car seat law from age 1 to age 5.The first booster seat law in 2005 requires mandatory use for ages 5 and 6, and optional use, based on size, for ages 7 through 11. New Mexico is now the first state to require that all children under the age of 18 wear a helmet on every recreational vehicle.//2008//

/2009/Safety training and home visitation programs are being developed concurrently to serve an expanded population of first time parents. 4-6 counties will be added to the home visitation program in the coming year. As federal funds are diminished, OIP is seeking funds from other sources and permanent state funds.//2009// ***/2010/Safety training for home visitation programs will continue to expand. Given budget constraints, it is unknown how many additional programs and counties will be added in the coming fiscal year. The Office of Injury Prevention is actively seeking private charity and foundation funding to augment***

the programs.//2010//

/2009/During 2007 the MCH Epi Program participated in the developmentof the NM Injury Prevention Coalition. This organization was initiated by OIP to increase community + governmental collaboration to increase awareness of injury risks and prevention.//2009//.

The Network Coalition against domestic and sexual violence continues to expand its influence and function well. The award winning video entitled "Stolen Childhood" has continued to be distributed widely.

The Dental Program/2009/Office of Oral Health program//2009//is funded by state general funds and works in close collaboration with the Title V MCH Program including collaboration on the submission of a HRSA grant for dental services. Family interest in oral health is rising; a fluoride varnish program for age 0-3/2009/0-4//2009// continues to provide services in 126 different schools throughout three counties. Coordination with Head Start is strong.

CMS had a system in place to coordinate with the Social Security Administration, State Disabilities Determination Services (DDS) unit to identify families in need of appeal assistance. A monthly list was generated by DDS and sent to CMS providing names of all families allowed or denied benefits. CMS staff would contact these families and inform them of services offered by the program.

/2008/The SSA/Disabilities Determination Unit (DDU) had a change in their computer software in 2005 that no longer allowed them to produce this report. CMS has had contact with the SSA Disabilities Determination Unit to remedy this problem so that we can once again receive the report so that we can continue to contact families. To date, SSA DDU has been unable to reproduce the report.//2008//

/2009/The SSA/DDU is now able to generate lists of clients that have been denied SSI. They are evaluating what information can be released per HIPAA and will then share with CMS who will work with the families.//2009//

CMS partners with the State Division of Vocational Rehabilitation in initiatives involving Youth Transition. DVR Representatives sit on the Healthy Transition Coordinating Council. CMS promotes use of its Transition Plan to facilitate planning for youth in several areas including employment, education and training.

The Family Leadership and Support Programs (ECAN, PRO) of the MCH Collaborative is a focal point for addressing MCH initiatives. The collaborative addresses Medical Home, the Transition of Youth with Special Health Care needs, and the Cultural Competence and Family Involvement Initiatives. Core partners include: UNM LEND, UNM Continuum of Care, Family Voices, PRO, and CMS, Parents of Behaviorally Different Children, Educating Parents of Indian Children with Special Health Care Needs (EPICS). The Health Systems Bureau Administrators for the RPHCA, the rural health funded centers, the Family Health Bureau, and particularly CYSHCN continue to work closely to assure dental, asthma and other special needs services are available statewide.//2007//

F. Health Systems Capacity Indicators

Introduction

/2009/The MCH programs' ability to maintain and improve HSCIs has been primarily from PRAMS, including addition of questions specific to indicators, vital records access, Medicaid & WIC data, and from SSDI support to strengthen data linkage capacity. Maintaining & improving capacity is continually hindered and/or delayed by inadequate data from Medicaid, hospital discharges, vital records and program case management. Improvement in vital records data is

expected with electronic record implementation in 2007, including payment source data needed for program planning related to Medicaid/non-Medicaid, or un-reimbursed care. SSDI was used to develop data systems for case management and service programs - including application development, training, and implementation for the Families First program - a prototype to be implemented for CMS and CYSHCN. SSDI-supported linkages across primary data sources (Medicaid, NM Vital Records, WIC, and PRAMS) are underway to improve NM program access & cost/benefit analysis. Comparisons for Medicaid, non-Medicaid, and all MCH populations are difficult due to imprecise state level poverty data on children in families eligible for Medicaid and SCHIP at NM eligibility levels. We are working to improve access to hospital discharge and procedure coding for birth defects surveillance while working with other programs to obtain more timely information on hospitalizations for asthma and injury. SSDI assists collaboration in all of these areas. /2009/Some of the SSDI fundes for FFY 09 will be used to hire a contractor to train MCH Epi staff in linkage of Medicaid and Birth Certificate files.//2009// ***/2010/Staffing shortages, budget cuts and a hiring freeze have delayed progress toward improvement in HSCIs.//2010//***

Health Systems Capacity Indicator 01: *The rate of children hospitalized for asthma (ICD-9 Codes: 493.0 -493.9) per 10,000 children less than five years of age.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	34.0	34.0	34.0	34.0	34.0
Numerator	464	464	474	474	474
Denominator	136637	136637	139300	139300	139300
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

Notes - 2008
2007 hospital discharge data are not yet available as of July 2009, but are expected to be available later in the summer.

Notes - 2007
2007 and 2008 Hospital Inpatient Discharge Data (HIDD) for asthma patients are not yet available.

Notes - 2006
Hospital Inpatient Discharge Data (HIDD) for asthma patients is from 2004. 2005 and 2006 data are not yet available.

Narrative:
Asthma hospitalization for children age 0-4 increased in the nine year period, 1995- 2003, from a reported 25.4 discharges per 10,000 children to 29.9/10,000, an increase of 10%. A 2006 surveillance report, the Burden of Asthma in New Mexico, showed the 1999-2003 average rate of asthma hospital discharges by county of residence, ranging from 0 to 139 per 10,000 children <5 years. In 2004, seventeen of NM's 33 counties were designated as Health Professional Shortage Areas (HPSA) for Primary Care (51.5% of the counties). The three counties with the highest

rates, Lea (139.0), Curry (113) and Roosevelt (88.6) are in Region 4 in the southwest corner of the state. The implications for the asthma hospital discharge data are that there continue to be places in the state where children do not have easy access to primary care. The state's Primary Care Bureau is working to address needs in HPSAs. Data limitations include 1) the Hospital Inpatient Discharge Data (HIDD) of the Health Policy Commission does not include Indian Health Service (I.H.S.) hospitals serving Navajo and Pueblo populations, 2)data for Native American children are under-represented and 3)the TVIS system does not allow for corrections in 2000-2001 data (there were errors in HIDD estimates)

In previous years, hospital inpatient discharge data revealed the following: Toddlers age 1 were more likely to be hospitalized than those age 3-4, and the rates for all children under age 4 were higher than for children ages 5 to 9 years. American Indian children age 0-4 had even higher rates of hospitalization for asthma than Hispanic or white children. Data for infants under one year are difficult to assess because of diagnostic difficulties in that age. In 2003, an estimated 8% of NM children <18 have asthma and of these 13.2% of asthmatic children's families are greatly or moderately affected by their condition; the U.S. figures were 8% and 16.3% respectively. (National survey children's health) ***/2010/ In 2007, an estimated 7.7% of NM children <18 currently have asthma (9% US rates), and of these 33.4% of parents rate their child's asthma as moderate (23% US), and 7.3% rate it as severe (5.6% US). //2010//***

The increased number of School-based Health Centers is expected to improve access to asthma care around the state. Project Envision New Mexico plans to bring asthma education to health professionals in rural areas. Since 1999 the New Mexico Asthma Coalition has been working cooperatively to bring community, statewide, and national partners together to address asthma issues in the state, and starting in 2003 it funded four special asthma clinics per year in Santa Fe with the NM Department of Health Children's Medical Services (CMS). CMS has a network of 60 medical social workers to provide asthma care coordination statewide. CMS provides 26 asthma outreach clinics throughout the State with UNM Children's Hospital Pediatric Pulmonary team (2 in Region 1, 11 in Region 5, 13 in Region 4). ***/2010/In FY2009 new partners were recruited and CMS provided 33 asthma outreach clinics in all Regions of the state, 23 with UNM's Pediatric Pulmonary Team, & 10 with Presbyterian Hospital's Pediatric Pulmonology Team.//2010//***

In 2005-06 after attrition of pediatric pulmonologists at University of New Mexico Hospital (UNMH) there were not enough specialists to cover the size of the present clinics provided statewide. In addition to participating in CMS clinics, the UNMH pulmonologists are required to cover clinics at UNMH and are responsible for adult cystic fibrosis patients as well as inpatients on ventilators in the UNM Hospital.

The number of clients attending CMS clinics was reduced from an average of 36 clients to 18 clients per clinic for half of the 26 clinics. The larger clinics allow for eight initial new patient visits with only one initial visit in smaller clinics. In FY '04, the total scheduled was 895, with 692 actually attending. In FY'05 970 children and youth with asthma were scheduled with 794 actually attending. The reduction in clinics will place the greatest burden on rural and frontier areas who have limited access to this specialty care. A statewide "Asthma Initiative" is being planned with DOH, UNMH, the Asthma Coalition, NM Pediatric Society, and other community partners to reassess asthma care in the state and formulate a new, coordinated, unified, collaborative statewide program.

/2010/In 2007-2008, a series of Asthma Summits were held in every Region of the state. Regions 1 and 4 were found to have the highest asthma rates, with Region 4 (Southeast NM) having the highest asthma hospitalization and ER rates for children. Strategies are being formulated to address the issues identified in the Summits. Advocates have been identified in each region to collaborate with DOH personnel to continue the work and the MCOs and NM Pediatric Society are involved in physician outreach to Region 4.//2010//

Health Systems Capacity Indicator 02: *The percent Medicaid enrollees whose age is less than one year during the reporting year who received at least one initial periodic screen.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	68.1	63.5	68.1	76.8	74.4
Numerator	13765	10927	13460	15880	16237
Denominator	20208	17218	19766	20684	21815
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2008
Denominator is the number or medicaid infants with DOB in FY '07 that were recipients of service. Numerator is medicaid infants with DOB in FY '07 that received at least one EPSDT screen.
Source: NM Medicaid Office. Data from October 1, 2007 - September 30, 2008.

Notes - 2007
Denominator is the number or medicaid infants with DOB in FY '07 that were recipients of service. Numerator is medicaid infants with DOB in FY '07 that received at least one EPSDT screen.
Source: NM Medicaid Office. Data from October 1, 2006 - September 30, 2007.

Notes - 2006
Denominator is the number of medicaid infants with DOB in FY '06 that were recipients of service. Numerator is medicaid infants with DOB in FY '06 that received at least one EPSDT screen.
Source: NM Medicaid Office. Data from October 1, 2005 - September 30, 2006.

Narrative:
The number of infants who received service from Medicaid born in FY 2004-05 was 17,218. Of these, 63.5% had an Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) screen. In 2005-06, of 19,766 Medicaid recipients born during the fiscal year, 68.1% had an EPSDT screen. This is a 4.6% increase from the previous year. The recent changes in re-enrollment requirements, from yearly to every six months, then back to yearly make it difficult to assess this indicator accurately. Also, hospitals and doctors may chart EPSDT services into other categories which prevents capturing the data accurately. It should be noted that even though 68% were recorded as screens paid for by Medicaid under one year, aggregate statistics for newborn hearing and newborn genetic screening indicate that of the total population of newborn babies in New Mexico, 94% received a hearing screen and 99% received a genetic screen. If the hearing and genetic screening are bundled into the cost of a hospital birth, and if the screen is not delineated on the bill, the hidden cost may also make it difficult to determine this indicator.

The EPSDT Advisory Committee of Medicaid, membership is comprised of agencies including the Human Services Department (HSD), Department of Health (DOH), Managed Care Organization (MCO) leadership, and professionals that are involved in assuring infant health care. This

committee meets bi-monthly and is working to improve the ability of providers in an MCO and direct fee for service environment to provide EPSDT services. The committee is also working to promote use of primary preventive care in the EPSDT category by all ages of children. In addition, due to mounting evidence of developmental and behavioral problems among young children ages one through five the need to screen and refer for anticipatory guidance has been noted as increasingly essential.

In the fall of 2005, a symposium called the Family Leadership Action Network (FLAN) was held to address increasing the percentage of children receiving EPSDT and developmental evaluations in their medical home. The Early Childhood Area Network (ECAN) and Parents Reaching Out (PRO) organized the symposium in response to a request by Gubernatorial Cabinet Secretaries. Issues included successes, barriers and strategies for improvement. There was considerable representation from pediatricians, family practitioners, early intervention agencies, Medicaid, the Title V agency, parents and other family members, UNM, Public Education Department and other key stakeholders. In response to the parents and representatives of this successful symposium the FLAN conference has become an annual event. Continuing with the strategy of involving families, in April 2007 the third FLAN conference was presented. The 2007 two-day conference focused on helping families find their voice to build the future and create change. Also featured, was a session on early brain development and the importance of play in the brain development of children.

Also in April 2007, ECAN held its annual Spring Policy Forum, "Turn the Curve." The day-long conference focused on using the New Mexico Children's Report Card and Children's Budget as tools to make a difference in the well-being of children and families. The discussion centered on, "What will it take to turn the curve on the health and well-being of New Mexico's young children and their families?" Each year a diverse group of citizens, who represent a variety of sectors and state agencies, is invited to attend. 75 participants attended the 2007 conference.

In the fall of 2006 a subcommittee of ECAN, the Developmental Screening Committee, prepared a 16-page booklet on "Improving Developmental Care for Young Children and their Families in New Mexico." This booklet was created with the provider in mind and has been distributed widely throughout the state to physicians, nurses, educators, child care providers, and parents.

/2009/The Children's Medical Services Family Infant Toddler Program provided screenings on approximately 100 Medicaid enrolled children under one year of age as a part child find and program intake activities, with the goal of enrolling those children into Early Intervention. At the 2008 FLAN conference, attendees met in small community mapping groups to discuss and make recommendations regarding family friendly services, education, health, early care and education, and family support and parenting education. The recommendations were provided to the Children's Cabinet at a Town Hall meeting on the second day of the conference. Many of the families attending have children with special needs. //2009//

/2010/ Over the last year, the Developmental Screening Initiative (DSI) has expanded it scope of work in promoting standardized developmental screening by implementing a community-organizing approach to intervention. DSI, in collaboration with Parents Reaching Out (PRO) has developed a parent-friendly Developmental Screening Record booklet, which includes other screenings and immunizations, as a tool for parents and caregivers in partnership with providers in the care of young children. This booklet, which is also available in Spanish, was unveiled at the state Family Leadership conference in April 2009. //2010//

Health Systems Capacity Indicator 03: *The percent State Childrens Health Insurance Program (SCHIP) enrollees whose age is less than one year during the reporting year who received at least one periodic screen.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	61.0	62.4	64.9	76.9	72.1
Numerator	164	196	159	143	178
Denominator	269	314	245	186	247
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2008
Source: NM Medicaid Office. Data from October 1, 2007 - September 30, 2008.

Notes - 2007
Source: NM Medicaid Office. Data from October 1, 2006 - September 30, 2007.

Notes - 2006
Source: NM Medicaid Office. Data from October 1, 2005 - September 30, 2006.

Narrative:
In 2005-06, of 245 infants born in the fiscal year and enrolled in SCHIP, 64.9% received at least one periodic screen compared to 62.4% in the previous 2004-05 fiscal yaer. The percent of enrolled SCHIP infants receiving at least one periodic screen increased from the previous three years but the number of screened SCHIP infants was highest in 2005.

The EPSDT Advisory Committee of Medicaid is comprised of members from agencies including the Human Services Department (HSD), Department of Health (DOH), MCO leadership, and professionals who are involved in assuring infant health care. This committee meets bi-monthly and is working to improve the ability of providers in an MCO and direct fee for service environment to provide EPSDT services and promotes use of primary preventive care in the EPSDT category by all ages of children. The committee is currently working on avenues that will improve the screening tool/guidelines.

A conference to address Early Period Screening, Diagnosis and Treatment (EPSDT) in New Mexico was held in 2005. The summit included a discussion of medical home and the integral nature of the medical home in addressing EPSDT issues. Professionals as well as family members were present to address concerns and provide their expertise. The summit was convened by the Early Childhood Action Network (ECAN) under the title Family Leadership Action Network (FLAN) in response to a request by the Children's Cabinet Secretaries from DOH, HSD, Public Education, Department of Aging, Department of Labor, and Department of Public Safety. An additional conference during the Spring of 2006, titled "Turn the Curve" was convened to address these concerns and move them forward to legislators and senators with the trust that these issues will be addressed. The Title V Directors/Manager and the CYSHCN and CMS FIT programs will continue to work with key state leaders from state agencies, parents, early intervention programs, medical providers/pediatricians, and the Interagency Coordinating Council non-profit agencies regarding EPSDT needs and plans resulting from the Developmental Screening Symposium to identify and address unmet EPSDT needs in New Mexico.

The Department of Health (DOH) Child Health Program and the Early Childhood Interagency Team (ECIAT) and Children Youth and Families Department (CYFD) reconvened with the Public Education Department to discuss ways to improve screening of young children. The barriers to screening of children were discussed as follows: There is no single data source that helps the state to understand the rates of developmental screening that is occurring in the state. The issue

that not only assessment of physical growth is important but the importance of high quality developmental screening that assesses emotional, social, motor and family issues on a regular basis across a young child's development. Recommendations were made on how to strengthen the system of developmental screening and how to collect data on the rate and quality of screening for children 0-5. The group determined that ensuring no child reaches kindergarten or Pre-K with an undetected developmental condition was at the heart of school readiness.

/2009/The Children's Medical Services Family Infant Toddler Program provided screenings on approximately 100 Medicaid enrolled children under one year of age as a part child find and program intake activities, with the goal of enrolling those children into Early Intervention. The NM Developmental Screening Initiative (DSI) was created through collaboration among ECAN, the Family Infant Toddler Interagency Coordinating Council, Envision New Mexico, the Center for Development and Disability, New Mexico Pediatric Society, and Parents Reaching Out organizations with support from the Commonwealth Fund and Assuring Better Child Health and Development. DSI provides the foundation for wide application of training on use of routine, standardized developmental screening and networking across disciplines throughout the system of care serving young children. //2009//

/20010/The Children's Medical Services Family Infant Toddler Program provided screenings on approximately 100 Medicaid enrolled children under one year of age as a part child find and program intake activities, with the goal of enrolling those children into Early Intervention. //2010//

Health Systems Capacity Indicator 04: *The percent of women (15 through 44) with a live birth during the reporting year whose observed to expected prenatal visits are greater than or equal to 80 percent on the Kotelchuck Index.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	53.7	58.2	63.1	66.0	66.0
Numerator	15173	16216	16785	18882	18882
Denominator	28246	27863	26608	28589	28589
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2008
2008 data not yet available.

Notes - 2007
Source: New Mexico Vital Records and Health Statistics.

Notes - 2006
The response rate to PRAMS for 2006 was less than 70%, therefore 2006 data should be interpreted with caution.

Narrative:

NM Vital Records provisional data in 2006 show that an estimated 59% achieved an observed to expected ratio of 80% on this index. NM has been one of the nation's poorest performers for prenatal care. Capacity is not adequate to the needs for prenatal care. The lack of willing and/or able providers results in some primary care clinics providing little to no prenatal care. High liability insurance rates for pregnancy care and the fear of litigation are significant disincentives to providing pregnancy care. In addition, pregnancy care is labor-intensive and not well reimbursed by Medicaid. Geographical access is a barrier to prenatal care in sparsely populated areas of NM, as it is for all health care. In some entire Counties prenatal care is not available. The Rural and Primary Health Care Program has agreed to attempt to collect data from their contracted primary care agencies on prenatal care provision and to provide what encouragement they can to the agencies to provide prenatal care. Maternal Health Program will also seek collaboration from the Public Health Division's County Health Councils Program to collect similar data and provide similar encouragement to the Health Councils of the individual counties. Such information may help in developing strategies for ameliorating access problems.

According to NM Vital Records data in 2005, the following types of women were less likely than others to receive adequate levels of prenatal care: American Indian women (14% of NM births), of whom approximately 40% started prenatal care after the first trimester or had no prenatal care; teens under 19 (10% of NM births), of whom about 39% started prenatal care after the first trimester or had no prenatal care; women with less than a high school education (27% NM births), of whom 41% started prenatal care after the first trimester or had no prenatal care; unmarried women (51% of NM births), of whom 36% started prenatal care after the first trimester or had no prenatal care; women born outside U.S. (19% of NM births), of whom 38% did not receive adequate prenatal care as described by the Kotelchuck index.

According to PRAMS data for 2004 to 2005, of women whose prenatal care or delivery were paid by Medicaid (59% of NM births), 38% started prenatal care after the first trimester or had no prenatal care. Fifty percent of women with late or no prenatal care reported that they started care as early as they wished. This suggests that many women do not value or desire early prenatal care. Focus groups done by the multi-agency Prenatal Care Task Force verify that for young Hispanic and Native American women, fear and shame are barriers to early prenatal care.

The High Risk Prenatal Care fund and local health offices serve indigent women, who often start prenatal care late in pregnancy, or do not access prenatal care, due to lack of funds. Title V supports four primary care clinics providing care to low-risk medically indigent women by paying for their routine lab tests, which otherwise would cost the women from $800 to $1,000, generally more than they can pay.

Prenatal care as it is commonly practiced presents little cultural relevance for women who are marginalized. These women tend to start prenatal care late or to not access it at all. This is demonstrated by the 2000 PRAMS data given above. Models of prenatal care in facilitated groups have demonstrated improved usage. The Family Health Bureau started eight pilot sites using such models, in public health offices, primary care sites and private offices. It actively supported attempts to start one at an Indian Health Service clinic, however, this venture has not been successful so far. Most of the clinics that started this model have discontinued it, due to what is perceived as inadequate staffing to begin or sustain it. More technical assistance and possibly financial assistance or incentive is needed to help clinics initiate and sustain the model. So far funding and staff have not been adequate to resume such support.

/2009/Provider shortages continue to be a problem for New Mexico. Of 33 counties in New Mexico, only Los Alamos county is not designated a health care provider shortage area. The MCH Epidemiology program and the Maternal Health Program are completing their comprehensive assessment of perinatal care and access which will be included in the 2010 Needs Assessment.//2009//

/2010/In 2008, Maternal Health Program did phone surveys of prenatal care/delivery

services in each of New Mexico's 33 counties. It and other studies showed deteriorating access to pregnancy care. Since 2005, 3 hospitals stopped delivery service. 12 of 33 counties have no hospital that provides delivery services. Seven (21%) counties have no prenatal care. 11.6% of the state's 2006 births were to residents of these counties. NM Health Policy Commission surveys show the number of counties lacking an Ob/Gyn practicing obstetrics jumped from 13 to 17 between 2001 and 2006. Increasing liability insurance premiums and low reimbursement rates have driven some providers to leave the state or quit obstetric services. Proposals are being developed for alternatives to the torts system for compensating those with poor birth outcomes and for reducing negligent practice. It is hoped that such an administrative system will reduce liability insurance costs, reduce litigation stress, and improve care quality, thereby increasing the number of obstetric providers and access to care. //2010//

Health Systems Capacity Indicator 07A: *Percent of potentially Medicaid-eligible children who have received a service paid by the Medicaid Program.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	80.6	86.3	98.2	94.3	94.3
Numerator	272894	254468	252493	235115	235115
Denominator	338489	294873	257246	249223	249223
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2008
2008 data not yet available.

Notes - 2007
Denominator: 43% of children, ages 1-20 in 2007 (579,589). Number of children is estimated by Bureau of Business and Economic Research; BBER does not provide projections for individual ages past 20. 43% is the estimated percentage of children living at or below 200% FPL.

Numerator: Source: NM Medicaid Office. Data from October 1, 20056- September 30, 2007. Medicaid report number AH290363
The number of medicaid children age 1-20, that are recipients of service.

Note on BBER data: Beginning with the population estimates for 2007, the University of New Mexico Bureau of Business and Economic Research (BBER) updated its estimates of age-specific migration with new data. This change caused a break in continuity between the 2006 and 2007 estimates. Older age groups were affected more than others. For rates calculated from BBER population estimates, any rate differences from 2006 to 2007 must be interpreted with caution, as they may be partly attributable to the change in population estimates used in the rate denominators.

Notes - 2006
Denominator: 43% of children, ages 1-20 in 2006. Number of children is estimated by Bureau of Business and Economic Research; BBER does not provide projections for individual ages past

20. 43% is the estimated percentage of children living at or below 200% FPL.

Numerator: Source: NM Medicaid Office. Data from October 1, 2005 - September 30, 2006. Medicaid report number AH270633. The number of medicaid children age 1-20, that are recipients of service.

Narrative:
According to the Medicaid MCH Statistical Report for 10/2005-9/2006, the total number of children ages 0-19 years enrolled was 316,934 of whom 272,259 (86%) received a service. A provisional estimate of 336,800 NM children ages 0-19 living at <185% FPL would be potentially eligible, with 81% receiving Medicaid services.
It is difficult to accurately assess the percent of potentially Medicaid eligible children in NM as population poverty estimates based on the 2000 US census become increasingly inaccurate across time with a high population growth rate for youth in NM. Medicaid eligibility measurement is further complicated by: 1) the automatic eligibility assumption for infants born in NM, 2) the recent frequent changes to enrollment requirements from one per year, to once every six months, and back to once per year, and 3) by the Federal changes in eligibility documentation requirements.

Alternate sources of children living at 185% of the poverty level might provide different estimates. State level poverty estimates for children are sparse and may be based on multiple conflicting sources. NM estimates of children living at or below 185% FPL (60%), and therefore potentially Medicaid eligible, are based on a 2002 report of the NM Taxation and Revenue Department. NM uses the most current 2005 population estimates from the University of New Mexico Bureau of Business and Economic Research (BBER) based on US Census data (561,388 children age 0-19). The 2005 National Survey of Child Health (NSCH) -- to be released in 2007 - may provide an indicator of the percent of families with at least one eligible child for use with census estimates of the number of children ages 0-19 years per family to assist in updating eligibility estimates.

Other factors possibly affecting enrollment data may be shifting in the time allowed for eligibility recertification. During the last two years, NM eliminated the 6-month re-certification for children, returning to a one year re-certification. The six-month re-certification resulted in children falling off eligibility, loss of coverage and care. The Department of Health Public Health Offices currently assists with Presumptive Eligibility and Medicaid On Site Application Assistance (PE/MOSAA), which assist many clients with the process of applying for Medicaid as well as the choosing of the Managed Care Organization (MCO) of their choice to provide services.
The DOH continues to work with Medicaid to increase provider reimbursement rates therefore, drawing in more providers within the Medicaid system. The Federal Poverty level for the SCHIP population remains at 235%. However, In July 2006 a program to increase eligibility for Medicaid started, the Premium Assistance for Kids (PAK) program which offers assistance for premiums for a commercial, comprehensive health insurance plan for children.

With the Governors' Insure New Mexico Initiative, health insurance coverage is being expanded regarding programs for 0-5 year olds and youth above age 19. These initiatives for Medicaid-like programs for non-Medicaid children and youth will assist with the working poor in this state. Through income disregard, children ages 0-5 are eligible for services up to 300% FPL. Expanded New Mexikids covers more children and pregnant women through traditional Medicaid, expanded State Children's Health Insurance Program and the new premium assistance program, which provides assistance for purchase of health insurance for children and pregnant women who do not qualify for certain state or federal programs. In addition, the State Coverage Initiative (SCI) Program was instituted in FY05 for employers with less than 50 employees. This program requires a minimal payment by both the employer and the employee and provides comprehensive health coverage.

The DOH continues to collaborate with the EPSDT Advisory Committee of Medicaid. Membership

is comprised of members from agencies including the Human Services Department (HSD), Department of Health (DOH) MCO leadership, and professionals that are involved in assuring infant health care. This committee meets bi-monthly and is working to improve the ability of providers in an MCO and direct fee for service environment to provide EPSDT services and to promote use of primary preventive care in the EPSDT category by all ages of children. The committee is currently working on avenues that will improve the screening tool/guidelines making it more user-friendly.

Health Systems Capacity Indicator 07B: *The percent of EPSDT eligible children aged 6 through 9 years who have received any dental services during the year.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	54.1	44.0	59.4	60.4	55.5
Numerator	41300	34297	45400	47449	46207
Denominator	76400	77965	76493	78498	83330
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2008
Source: NM Medicaid office. Data are from October 1, 2007 - September 30, 2008.

Notes - 2007
Source: Medicaid MCH Statistical Report FFY 07, number AH280617.

Notes - 2006
Source: NM Medicaid office. Data are from October 1, 2005 - September 30, 2006.

Narrative:
Between 2000-2006, the proportion of children on Medicaid and who received any dental service gradually increased from 34% to 59% of clients ages 6-9 years. In that period the number of children doubled from almost 20,000 to more than 45,000. This progress is attributed to many factors: the Department of Health (DOH) worked with Medicaid to obtain higher rates for dental services and efforts to recruit more dentists who would accept Medicaid payment. All but 8 of the 33 counties are designated as health professional shortage areas (HPSAs) for dental care.

Between 2005 and 2006 the number of children ages 6-9 who were clients was 76,493 and 45,400 of those were recipients of dental services The number of children eligible to receive services will undoubtedly continue to increase this coming year since Medicaid re-certification will be changing from every six (6) months to every 12 months. This will assist with children receiving continued coverage as well as continuity of care. The 6-month re-certification posed problems with children falling off eligibility, resulting in loss of coverage and care. Another factor that will increase children obtaining dental services is the continued efforts by DOH working with Medicaid to increase dental reimbursement rates.

New Mexico has a lower coverage by dentists compared to nationally. The estimate for the number of dentists in New Mexico ranges from 32.4 to 43.7 per 100,000 populations. This is well

below the national rate of 63.6 per 100,000 populations. The dentists in New Mexico are not evenly distributed, approximately 50-60% of practicing dentists in the state, practice in NE Albuquerque, which is a metro area as compared to the remainder of New Mexico which is quite rural. Access to dental care is limited in New Mexico. This can be attributed to the lack of dentists in the state, low reimbursement by Medicaid and the number of people that have no dental insurance. OOH has partnered with private school based companies to increase the number of children receiving preventive dental treatment.

The OOH is continuing its efforts to work with the NM Dental Board and NM Oral Health Council to increase access for dental care. The OOH continues to support public-private partnerships with hopes to increase dental services to the lower income children. The OOH continues to use general funds to support low-income families who do not qualify for Medicaid but are in need of dental treatment. The OOH continues to use general funds to support the ongoing sealant program.

/2009/The impact of the changes to Medicaid re-enrollment is not yet known.//2009//

/2010/OOH continues to work with the NM Oral Health Council and the Governor's Oral Health Council to increase oral health awareness, expand the scope of practice for dental hygienists, revamp the NM Dental Health Care regulations to increase the number of dentist serving the State. Despite the economic down turn the State has maintained the programs budget for FY 10.//2010//

Health Systems Capacity Indicator 08: *The percent of State SSI beneficiaries less than 16 years old receiving rehabilitative services from the State Children with Special Health Care Needs (CSHCN) Program.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	5.1	5.2	3.5	3.4	3.4
Numerator	280	274	274	274	274
Denominator	5450	5269	7781	8092	8092
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

Notes - 2008

7,323 children under 16 received SSI benefits in 2008. The Children's Medical Services Program (CMS) is transitioning to a new data system, and the number of CMS clients that are also SSI beneficiaries is not currently available.

Notes - 2007

Denominator Source:

http://www.ssa.gov/policy/docs/statcomps/ssi_sc/2007/nm.pdf

The Children's Medical Services Program (CMS) is transitioning to a new data system, and the number of CMS clients that are also SSI beneficiaries is not currently available.

Notes - 2006
This is a very rough estimate. NM Social Security Administration doesn't enumerate by age, only by over or under 18. Children covered by the CMS CYSHCN Program do not qualify for SSI because they are immigrants. For the children and youth served by the CMS program, those on SSA are Medicaid clients who receive only care coordination from the program.

Denominator Source: http://www.ssa.gov/policy/docs/statcomps/ssi_sc/2006/nm.pdf

Numerator Source: Children's Medical Services Program

Narrative:
There continues to be concern over a gap in coverage for services addressing chronic orthopedic and rehabilitation needs of uninsured children and youth in New Mexico. The merger of Carrie Tingley Hospital (which used to provide these services to children with no insurance, Medicaid, or other payor source) with the University of New Mexico (UNM) Medical Center resulted in a change in the coverage of rehabilitative services. Currently, UNM Carrie Tingley Hospital is not providing rehabilitative services to patients unless they are able to pay out of pocket.

The Children's Medical Services (the state CSHCN Program) is placing children and youth with special diagnoses on the New Mexico Medical Insurance Pool. This is the only way that CYSHCN will receive orthopedic coverage. The coverage is far greater than the $15,000 limit for CMS CYSHCN and more comprehensive. The gap in coverage for chronic orthopedic and rehabilitative services described above results in disparate coverage for immigrant (mostly Hispanic) children, since most are unable to pay out of pocket for such services. Funding was appropriated by the Legislature to Carrie Tingley Hospital in the l980's. Until this funding is shared with the Title V CYSHCN Program, no services will be provided to immigrants who do not qualify for SSI Medicaid.

Since learning of the CMS CYSHCN effort to place children and youth on the New Mexico Medical Insurance Pool (NMMIP), Carrie Tingley is now placing them on NMMIP before referring to CMS. While this apprears helpful, it may be greater cost to the CMS program as some diagnoses cost less than the NMMIP deductible and co-pay.

The 2007 Legislature awarded CMS $500,000 in additional funds: $300,000 will be utulized to incerease the number of children enrolled in NMMIP by 80 with an emphasis on children with orthopedic needs, $100,000 to enhance services to the Deaf/Hard of Hearing Community, and $100,000 to the Blind and Visually Impaired Community.

/2009/CMS met with Carrie Tingley Hospital to discuss orthopedic care for CYSHCN with orthopedic needs. CTH has now agreed to provide orthopedic care to non-Medicaid eligible CYSHCN when the care is ‘medically necessary'. That determination will be made by the Orthopedic specialist, with appeal privilege given to the CMS Medical Director. This is a major change in orthopedic care for non-Medicaid eligible children in New Mexico. The initial $500,000 from the legislature is now part of the recurring budget for CMS. Children with unmet orthopedic conditions will continued to be enrolled onto NMMIP. The Commissions for the Deaf and Hard of Hearing and the Blind are using the money to address unmet needs of children who are deaf or hard of hearing or are blind especially school aged where there are many gaps in services.//2009//

/2010/ Carrie Tingley Hospital reversed their decision this year to provide orthopedic care to non-Medicaid eligible children. CMS continues to enroll children onto NMMIP to address unmet orthopedic needs. The Commissions for the Deaf and Hard of Hearing and the Blind

continue to use their funds to address unmet needs of children who are deaf or hard of hearing or are blind with a focus on technology.//2010//

SSI and Medicaid/SCHIP continue to be the major providers of the rehabilitative care in New Mexico. An additional program has been formed to cover all resident children age birth to 5. This begins to close the gap on uninsured children who need orthopedic and rehabilitative care. Additional programs and/or funding are needed to close this gap.

A December 2005 breakdown of SSI recipients by county for children under 18 is as follows:

Total New Mexico 7,180
Bernalillo 1,917
Catron 7
Chaves 281
Cibola 140
Colfax 63
Curry 210
DeBaca 11
Dona Ana 836
Eddy 165
Grant 91
Guadalupe 21
Harding *
Hidalgo 18
Lea 196
Lincoln 42
Los Alamos *
Luna 92
McKinley 590
Mora 25
Otero 192
Quay 43
Rio Arriba 148
Roosevelt 82
Sandoval 292
San Juan 598
San Miguel 156
Santa Fe 329
Sierra 37
Socorro 135
Taos 70
Torrance 70
Union 14
Valencia 306

SSI beneficiaries are offered care coordination services by the CMS CYSHCN program. Medicaid Salud! coverage in New Mexico is comprehensive; CMS assists families when their monthly income exceeds SSA limits (but still falls within CMS financial eligibility guidelines). CMS Social Workers also assist SSI recipients turning 18 to apply for benefits as adults. At one time CMS continually received a monthly list from New Mexico's Disability Determination Services program (DDS) providing names of all families allowed or denied benefits. CMS would contact these families and inform them of services offered by the program, such as care coordination. For those denied benefits, information about Parents Reaching Out, a Statewide Parent-to-Parent Organization would be provided. During FY 03, a change in the local Social Security Office computer system disabled capacity to generate an SSI denial list. Social Security is still working to remedy this problem.

/2009/Children's Medical Services (CMS) program is implementing the use of its case management software. The program plans to begin collecting information about client income in 2009-2010, which will yield an accurate count of SSI beneficiaries that also receive rehabilitative services from CMS.//2009//

Health Systems Capacity Indicator 05A: *Percent of low birth weight (< 2,500 grams)*

INDICATOR #05 ***Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State***	**YEAR**	**DATA SOURCE**	**POPULATION**		
			MEDICAID	**NON-MEDICAID**	**ALL**
Percent of low birth weight (< 2,500 grams)	2007	other	6.4	5.6	6.1

Notes - 2010
Source: 2006 PRAMS

Narrative:
The most recent birth+Medicaid report was 2000. NM PRAMS is the only current source of data that compares Medicaid with non-Medicaid paid mothers and infants until NM VRHS has adequate resources to link the birth file to Medicaid, and potentially the infant birth+death file to Medicaid.

Indicator 05A: Vital records data for 2005 show that 8.5% of all births to NM residents were low birth weight (<2500 grams). The overall percentage low birth weight in the NM PRAMS sample for 2004-05 was 7.9% and NM PRAMS estimates show that Medicaid paid for 57% of all deliveries in 2004-05. By payer of delivery care, the percentage low birth weight among Medicaid-paid births was 68.2% and 7.7 among non-Medicaid paid births, a statistically significant difference.

For three of the four indicators, NM PRAMS data was available to compare Medicaid and non-Medicaid populations. For each of these indicators, the Medicaid population fared worse than the non-Medicaid population. The detailed report produced by VRHS based on the linkage of 1999-2000 birth records with Medicaid data found that, compared to non-Medicaid mothers, a greater percentage of Medicaid mothers were young, White/Hispanic, and had fewer years of education. Medicaid mothers received lower levels of prenatal care, and were more likely to give birth to low birth weight infants. The report compared outcomes for Medicaid Fee for Service and Medicaid Managed Care, and found that the Fee for Service mothers received lower levels of prenatal care and their infants were more likely to be low birth weight compared to Medicaid mothers in managed care.

/2009/The 2003 report compared outcomes for Medicaid Fee for Service and Medicaid Managed Care, and found that the Fee for Service mothers received lower levels of prenatal care and that their infants were more likely to be low birth weight compared to Medicaid mothers in managed care. Medicaid mothers were less likely to access 1st trimester prenatal care, and they were more likely to give birth to low birth weight infants (10% among fee-for-service, 8.4% among Salud!, and 6.9% among non-Medicaid births)//2009//

/2010/The PRAMS report of 2004-2005 data showed that 10.5% of mothers whose care was paid by Indian Health Service, with or without Medicaid, gave birth to low birth weight

babies. For mothers whose care was paid by Medicaid, 7.6% of their babies were low birth weight, and for mothers with private insurance, 8.5% had low birth weight babies. For mothers with no care, 6.5% delivered low birth weight babies. Twenty-eight percent of mothers whose care was paid by Indian Health Service had inadequate prenatal care, 21% of mothers whose care was paid by Medicaid had inadequate care, and 12% of mothers with private insurance had inadequate care. For those with no insurance, 30% had inadequate care.//2010//

Health Systems Capacity Indicator 05B: *Infant deaths per 1,000 live births*

INDICATOR #05 ***Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State***	**YEAR**	**DATA SOURCE**	**POPULATION**		
			MEDICAID	**NON-MEDICAID**	**ALL**
Infant deaths per 1,000 live births	2006	other	6	6	6.3

Notes - 2010
The difference between Medicaid and Non-Medicaid infnat deaths is not available at this time. "6" is a very rough estimate. This information will be available when 2008 NMVRHS data become available.

Narrative:
The most recent birth+Medicaid report was 2000. NM PRAMS is the only current source of data that compares Medicaid with non-Medicaid paid mothers and infants until NM VRHS has adequate resources to link the birth file to Medicaid, and potentially the infant birth+death file to Medicaid.

Indicator 05B: Infant deaths per 1000 live births for NM residents has declined from 7.1 in 1998 to 6.3 in 2004, though this is an 11% increase from the 2002 rate. Data on this indicator are not available for Medicaid and non-Medicaid populations, but this decline was observed across all race/ethnicity groups. The 2004 Vital Records report shows that inn 2003 the NM infant mortality rate was 21.7% lower than the US rate of 6.9% and 10% lower than that of the the Mountain Census Region.

For three of the four indicators, NM PRAMS data was available to compare Medicaid and non-Medicaid populations. For each of these indicators, the Medicaid population fared worse than the non-Medicaid population. The detailed report produced by VRHS based on the linkage of 1999-2000 birth records with Medicaid data found that, compared to non-Medicaid mothers, a greater percentage of Medicaid mothers were young, White/Hispanic, and had fewer years of education. Medicaid mothers received lower levels of prenatal care, and were more likely to give birth to low birth weight infants. The report compared outcomes for Medicaid Fee for Service and Medicaid Managed Care, and found that the Fee for Service mothers received lower levels of prenatal care and their infants were more likely to be low birth weight compared to Medicaid mothers in managed care.

/2009/The 2003 report compared outcomes for Medicaid Fee for Service and Medicaid Managed Care, and found that the Fee for Service mothers received lower levels of prenatal care and that their infants were more likely to be low birth weight compared to Medicaid mothers in managed care. Medicaid mothers were less likely to access 1st trimester prenatal care, and they were more

likely to give birth to low birth weight infants (10% among fee-for-service, 8.4% among Salud!, and 6.9% among non-Medicaid births)//2009//

/2010/In 2007, New Mexico's infant mortality rate was 6.0 per 1,000 live births. NM Vital Records and Health Statistics is still slightly delayed in releasing 2007 and 2008 data due to their conversion to a new web-based system, during which they also adopted the NCHS birth certificate standard. Infant deaths by payer of care should be available when these data are released. The SSDI director is participating in the W.K. Kellogg Foundation's Working Group on Infant Mortality and Optimizing Birth Outcomes to explore solutions to poor birth outcomes.//2010//

Health Systems Capacity Indicator 05C: *Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester*

INDICATOR #05 ***Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State***	**YEAR**	**DATA SOURCE**	**POPULATION**		
			MEDICAID	**NON-MEDICAID**	**ALL**
Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester	2007	other	66.8	78.8	72.8

Notes - 2010
Source: 2006 PRAMS

Narrative:
The most recent birth+Medicaid report was 2000. NM PRAMS is the only current source of data that compares Medicaid with non-Medicaid paid mothers and infants until NM VRHS has adequate resources to link the birth file to Medicaid, and potentially the infant birth+death file to Medicaid.

Indicator 05C: Vital records data for births in 2005 indicate that 70.31% of pregnant women entered prenatal care in the first trimester. In the PRAMS sample, the overall estimate for 2004-05 was 73.2%. The percentage of pregnant women who received prenatal care in the first trimester was 53.6% among Medicaid-paid births, and 46.4% among non-Medicaid paid births, a statistically significant difference.

For three of the four indicators, NM PRAMS data was available to compare Medicaid and non-Medicaid populations. For each of these indicators, the Medicaid population fared worse than the non-Medicaid population. The detailed report produced by VRHS based on the linkage of 1999-2000 birth records with Medicaid data found that, compared to non-Medicaid mothers, a greater percentage of Medicaid mothers were young, White/Hispanic, and had fewer years of education. Medicaid mothers received lower levels of prenatal care, and were more likely to give birth to low birth weight infants. The report compared outcomes for Medicaid Fee for Service and Medicaid Managed Care, and found that the Fee for Service mothers received lower levels of prenatal care and their infants were more likely to be low birth weight compared to Medicaid mothers in managed care.

/2009/The 2003 report compared outcomes for Medicaid Fee for Service and Medicaid Managed Care, and found that the Fee for Service mothers received lower levels of prenatal care and that

their infants were more likely to be low birth weight compared to Medicaid mothers in managed care. Medicaid mothers were less likely to access 1st trimester prenatal care, and they were more likely to give birth to low birth weight infants (10% among fee-for-service, 8.4% among Salud!, and 6.9% among non-Medicaid births)//2009//

/2010/The PRAMS report of 2004-2005 births shows that by payer of care, 61.5% of women on Medicaid received adequate or intensive prenatal care, 55.9% of Indian Health Service recipients received adequate care, 72.1% of private insurance recipients received adequate care, and only 52.6 percent of women with no insurance received adequate care. According to the 2006 report by New Mexico Vital Records and Health Statistics, (NMVRHS) 71.6 percent of births were to mothers that began prenatal care in the first trimester. In the 2004-2005 PRAMS report women cited Inability to get an appointment, not having money or insurance, and not having a Medicaid card as the top three reasons they couldn't get prenatal care when they wanted it. In 2006, 67.9% of Medicaid covered births were to women that began prenatal care in the first trimester, and 78.2% of births covered by other kinds of insurance were to women who began care in the first trimester. NMVRHS has not yet released birth data by payer of care for 2007 and 2008. Issues surrounding access to health care for pregnant women are discussed in the narrative for National Performance Measure 18.//2010//

Health Systems Capacity Indicator 05D: *Percent of pregnant women with adequate prenatal care(observed to expected prenatal visits is greater than or equal to 80% [Kotelchuck Index])*

INDICATOR #05 ***Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State***	**YEAR**	**DATA SOURCE**	**POPULATION**		
			MEDICAID	**NON-MEDICAID**	**ALL**
Percent of pregnant women with adequate prenatal care(observed to expected prenatal visits is greater than or equal to 80% [Kotelchuck Index])	2007	other	69	69.1	69.3

Notes - 2010
Source: 2006 PRAMS

Narrative:
The most recent birth+Medicaid report was 2000. NM PRAMS is the only current source of data that compares Medicaid with non-Medicaid paid mothers and infants until NM VRHS has adequate resources to link the birth file to Medicaid, and potentially the infant birth+death file to Medicaid.

Indicator 05D: For all births to NM residents in 2005, 58.9% of pregnant women achieved adequate or adequate-plus utilization of prenatal care by the Kotelchuck index (i.e., they received 80% or greater of the expected number of prenatal care visits). For the sample of NM PRAMS births in 2004-05, 63.0% of pregnant women received adequate or greater prenatal care. Among Medicaid-paid births, the percentage was significantly lower at 60.2% compared to non-Medicaid-

paid births at 66.7%.

For three of the four indicators, NM PRAMS data was available to compare Medicaid and non-Medicaid populations. For each of these indicators, the Medicaid population fared worse than the non-Medicaid population. The detailed report produced by VRHS based on the linkage of 1999-2000 birth records with Medicaid data found that, compared to non-Medicaid mothers, a greater percentage of Medicaid mothers were young, White/Hispanic, and had fewer years of education. Medicaid mothers received lower levels of prenatal care, and were more likely to give birth to low birth weight infants. The report compared outcomes for Medicaid Fee for Service and Medicaid Managed Care, and found that the Fee for Service mothers received lower levels of prenatal care and their infants were more likely to be low birth weight compared to Medicaid mothers in managed care.

/2009/The 2003 report compared outcomes for Medicaid Fee for Service and Medicaid Managed Care, and found that the Fee for Service mothers received lower levels of prenatal care and that their infants were more likely to be low birth weight compared to Medicaid mothers in managed care. Medicaid mothers were less likely to access 1st trimester prenatal care, and they were more likely to give birth to low birth weight infants (10% among fee-for-service, 8.4% among Salud!, and 6.9% among non-Medicaid births)//2009//

/2010/New Mexico Vital Records and Health Statistics (NMVRHS) reports in 2006 that 61.1% of births were to women whose prenatal care use was considered at least "adequate." Sixty-two percent of Medicaid births and 64.5% of non-Medicaid births were to women with adequate usage. NMVRHS began using a new, web-based birth certificate in July, 2007. 2007 and 2008 prenatal care by payer of care data will be available when the transition to the new system is complete.//2010//

Health Systems Capacity Indicator 06A: *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Infants (0 to 1)*

INDICATOR #06 **The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL Medicaid**
Infants (0 to 1)	2008	185
INDICATOR #06 **The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL SCHIP**
Infants (0 to 1)	2007	235

Narrative:
In New Mexico, infants age 0-1 are eligible for Medicaid if their family income is less than or equal to 185% of the federal poverty level (FPL), provided they meet other criteria. Infants are eligible for SCHIP if their family income is less than or equal to 235% FPL.

The Family Health Bureau (FHB) staff participates in the EPSDT-Medicaid Advisory Committee. FHB works with partners to identify statewide strategies to address issues of uninsured or underinsured. Families FIRST and CMS programs complete Presumptive Eligibility/Medicaid On Site Application Assistance (PE/MOSAA) applications for eligible children or youth.

Medicaid has changed the six-month renewal policy back to a twelve-month renewal process. A current barrier to access is the requirement of a birth certificate to qualify for Medicaid. The Department of Health (DOH) is working collaboratively with the Human Services Department (HSD) to identify community events that would provide opportunities for outreach and Medicaid enrollment of eligible children. DOH is also working collaboratively with HSD to increase the

number of eligible children enrolled in Medicaid, and to address the birth certificate requirement to qualify for Medicaid. DOH will continue to reach out to children and families to increase the number of children who are insured. This includes the efforts of Families FIRST and CMS staff who are actively involved in assisting families to complete the PE/MOSSA application.

The Children's Cabinet is working with the Governor and State Legislature to address universal coverage for children. In July 2006 Medicaid's six month reenrollment was changed back to the one year reenrollment requirement. Information is being shared with families about the availability of funds to assist families with the cost of health insurance premiums. A bill to increase the SCHIP eligibility to 300% FPL was defeated in the 2006 legislative session, however, HSD has increased the amount of income that can be disregarded and the amounts that can be deducted from gross income, making it possible for children age 0-5 to receive SCHIP at up to 300% FPL. The Children's Cabinet plans to continue to work with the Governor and the State Legislature to implement universal health care coverage for all New Mexicans, including children.

/2010/There is no new information to report for this indicator.//2010//

Health Systems Capacity Indicator 06B: *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Medicaid Children*

INDICATOR #06 **The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL Medicaid**
Medicaid Children (Age range 1 to 19) (Age range to) (Age range to)	2008	185
INDICATOR #06 **The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL SCHIP**
Medicaid Children (Age range 1 to 19) (Age range to) (Age range to)	2007	235

Narrative:
In New Mexico, children <19 are eligible for Medicaid if their family income is less than or equal to 185% of the federal poverty level (FPL), provided they meet other criteria. Children age 1-18 are eligible for SCHIP if their family income is less than or equal to 235% FPL.

About 21,000 children, 5 years old and under are uninsured in New Mexico.

The Family Health Bureau (FHB) staff participates in the EPSDT-Medicaid Advisory Committee. FHB works with partners to identify statewide strategies to address issues of uninsured or underinsured. Families FIRST and CMS programs complete Presumptive Eligibility/Medicaid On Site Application Assistance (PE/MOSAA) applications for eligible children or youth.

Medicaid has changed the six-month renewal policy back to a twelve-month renewal process. A current barrier to access is the requirement of a birth certificate to qualify for Medicaid. The Department of Health (DOH) is working collaboratively with the Human Services Department (HSD) to identify community events that would provide opportunities for outreach and Medicaid

enrollment of eligible children. DOH is also working collaboratively with HSD to increase the number of eligible children enrolled in Medicaid, and to address the birth certificate requirement to qualify for Medicaid. DOH will continue to reach out to children and families to increase the number of children who are insured. This includes the efforts of Families FIRST and CMS staff who are actively involved in assisting families to complete the PE/MOSSA application.

The Children's Cabinet is working with the Governor and State Legislature to address universal coverage for children. In July 2006 Medicaid's six month reenrollment was changed back to the one year reenrollment requirement. Information is being shared with families about the availability of funds to assist families with the cost of health insurance premiums. HSD has increased the amount of income that can be disregarded and the amounts that can be deducted from gross income, making it possible for children age 0-5 to receive SCHIP at up to 300% FPL. The Children's Cabinet plans to continue to work with the Governor and the State Legislature to implement universal health care coverage for all New Mexicans, including children.

The MCH programs' ability to maintain and improve HSCIs has been primarily from PRAMS, including addition of questions specific to indicators, vital records access, Medicaid & WIC data, and from SSDI support to strengthen data linkage capacity. Improvement in vital records data is expected with electronic record implementation in 2007, including payment source data needed for program planning related to Medicaid/non-Medicaid, or un-reimbursed care.

/2010/There is no new information to report on this indicator.//2010//

Health Systems Capacity Indicator 06C: *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Pregnant Women*

INDICATOR #06 **The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL Medicaid**
Pregnant Women	2008	185
INDICATOR #06 **The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL SCHIP**
Pregnant Women		

Notes - 2010
SCHIP does not cover pregnant women in New Mexico.

Narrative:
Pregnant women are not covered by SCHIP in New Mexico. Pregnant women qualify for Medicaid if their income is less than or equal to 185% FPL, provided they meet other criteria.

The New Mexico Medicaid policy was successfully changed, and the Maternal Health Program participated in developing systems so that professional out-of-hospital birth attendants will be paid by Medicaid Managed Care Organizations for delivery services even when liability insurance cannot be obtained at less than 25% of the provider's practice income. A home birth is less expensive, and for some women it is their preference. This should improve pregnancy care access.

MCH is meeting with the Public Health Division's Health Systems Bureau personnel, Governor's Women's Health Commission, leadership of the New Mexico Primary Care Association, and state Medicaid administrators to identify strategies for increasing access to prenatal care throughout

the state.

Title V MCH and State General funds are being used to cover services to pregnant women (High Risk Prenatal Fund) and children (Healthier Kids Fund) who have no other source of health care coverage.

The MCH programs' ability to maintain and improve HSCIs has been primarily from PRAMS, including addition of questions specific to indicators, vital records access, Medicaid & WIC data, and from SSDI support to strengthen data linkage capacity. Improvement in vital records data is expected with electronic record implementation in 2007, including payment source data needed for program planning related to Medicaid/non-Medicaid, or un-reimbursed care.

/2010/There is no new information to report on this indicator. A thorough discussion of poverty level as a measure of eligibility for aid is available in the narrative for Health Status Indicator 11.//2010//

Health Systems Capacity Indicator 09A: *The ability of States to assure Maternal and Child Health (MCH) program access to policy and program relevant information.*

DATABASES OR SURVEYS	**Does your MCH program have the ability to obtain data for program planning or policy purposes in a timely manner? (Select 1 - 3)**	**Does your MCH program have Direct access to the electronic database for analysis? (Select Y/N)**
ANNUAL DATA LINKAGES Annual linkage of infant birth and infant death certificates	2	No
Annual linkage of birth certificates and Medicaid Eligibility or Paid Claims Files	2	No
Annual linkage of birth certificates and WIC eligibility files	1	No
Annual linkage of birth certificates and newborn screening files	2	No
REGISTRIES AND SURVEYS Hospital discharge survey for at least 90% of in-State discharges	1	No
Annual birth defects surveillance system	2	No
Survey of recent mothers at least every two years (like PRAMS)	3	Yes

Notes - 2010

Narrative:
NM has stronger capacity to produce data and information for use in programmatic and policy development with staff replacement this year. Delays in obtaining data occurred due to resource shortages, including support for birth defects surveillance. The Title V agency has access to aggregate data reports and/or individual electronic data files within the DOH and across many agencies for assessment and evaluation purposes. The most important weaknesses may be for evaluation studies and benefit-cost analysis, partially due to lack of cost data. Most data are from surveillance or required reporting systems.

The Human Services Department works closely with Title V MCH but had systems delays for Medicaid and EPSDT reporting. The Bureau of Vital Records and Health Statistics (VRHS) in DOH makes individual level record files for births and deaths available to DOH epidemiologists through a data sharing agreement. New staffing within the MCH Epidemiology Program will now afford greater use of analytic methods, a critical step in understanding MCH issues.

Annual linkage infant birth+death: VRHS performs linkage on an ongoing basis. The most current linked file is for 2004 births + 2004/2005 deaths. The most current analysis of infant mortality, using 1998-99 data, featured standard infant mortality descriptive analysis.

Annual linkage birth+Medicaid: Linked data from 1995-2003 are complete and used to monitor Medicaid coverage and to learn from differences between Medicaid and non-Medicaid paid outcomes. Striking differences between managed care organization and fee for service client outcomes are shown.
Annual Linkage birth+WIC: SSDI supported preparation of 2000-2005 WIC data for analysis of the Title V NPM 14 with a 2006 update this year. Linkage of WIC with PRAMS, the birth+death file and Medicaid will help to ascertain the percent of Medicaid eligible mothers and children who are using WIC and to evaluate questions about WIC's impact on Medicaid costs. /2009/WIC was linked to PRAMS. WIC data are being prepared to link to birth certificates.//2009//

Hospital Inpatient Discharge Data (HIDD): NM Health Policy Commission (HPC) provides data from mandated reporting by community and specialty hospitals (excluding federal, Indian Health, and military). The DOH has been working with the HPC to strengthen data quality in the system; and the analysis of data for topics like childhood asthma hospitalizations and injuries. NM HIDD system has voluntary E-coding, and as of 2003, the most recent available year, was coding about 65% of hospitalizations for injury. /2009/HIDD is still not available to the Maternal and Child Health programs//2009//

Newborn Hearing Screening: The electronic birth registration system includes variables for hearing screening results used to track and follow up on newborns who did not pass the screen before discharge or who were discharged without a screen. Monthly birth files are used by the Newborn Hearing Screening program to perform follow up. A system approach to tracking infants born out of hospital is underway with the Maternal Health Program.

Annual birth defects surveillance: NM had state and CDC grant support through 2005. State funds for birth defects and a registry of CSHCN were redirected to cover cuts in funds for direct services within the CMS program. Lacking funding and resources, a more limited birth defects system is used that focuses on neural tube defects, cleft lip and/or palate, and gastroschisis. A preliminary, descriptive analysis of linked birth defects+ birth+death was completed in the first quarter of 2007. In the next year, the program anticipates being able to combine funds from at least 3 sources to create a web-based newborn screening birth defects tracking system to include case management. /2009/ChallengerSoft software is being used for the birth defects tracking//2009// We continue to work to identify resources for support this effort.

Survey recent mothers: NM PRAMS has a cooperative agreement with CDC through April 2011.

PRAMS is used extensively for policy and programmatic development. Until such time as the linked birth+Medicaid project can move forward, PRAMS estimates are used for reporting on Medicaid and Non-Medicaid prenatal care and perinatal factors.

Other data systems: 1) The NM Behavioral Risk Factor Surveillance System; 2) the NM Youth Risk Resiliency Survey (includes resiliency topics in CDC YRBS); 3) statewide Office of Medical Investigator system; 4) NM Child Fatality Review . The federal MCHB-sponsored surveys of Children with Special Health Care Needs and National Survey of Child Health are well used.

/2009/The MCH Epidemiology program is making data access/linkage a priority. Issues about data availability are being addressed through a series of meetings and agreements with key personnel in other programs to streamline data sharing and enhance analytical capacity.//2009//

/2010/Barriers to data access include delays in files, reports and analysis for Medicaid, hospital discharges, INFORM (a multi-source state population-based data system), and vital records. Many programs are are short-staffed, are in the midst of modifying their data management systems, or have recently modified them and are still working to produce datasets in the new formats. Hospital Inpatient Discharge Data has been unavailable, however 2008 legislation has made it possible for HIDD to be shared with the NM Department of Health.//2010//

Health Systems Capacity Indicator 09B: *The Percent of Adolescents in Grades 9 through 12 who Reported Using Tobacco Product in the Past Month.*

DATA SOURCES	Does your state participate in the YRBS survey? (Select 1 - 3)	Does your MCH program have direct access to the state YRBS database for analysis? (Select Y/N)
Youth Risk Behavior Survey (YRBS)	3	No

Notes - 2010

Narrative:
NM has two sources for this data: the Youth Risk Resiliency Survey (YRRS) done in odd years, and Youth Tobacco Survey done in even years; the latter includes middle school children. An estimated 30.7% of NM youth reported using tobacco products within 30 days before the 2005 YRRS survey. This prevalence was not statistically significantly different from the national rate of 28.4%, or the 34.0% rate from 2003. Smoking did increase in the 1990s (38-39% in NM youth) and shows a decrease in the 2000s. In the 2005 YRRS report, boys (27.4%) smoked more than girls (23.8%).

Among middle school age children in the 2004 NM Youth Tobacco Survey, current smokers included 5.1% of 6th graders, and 16% of 8th graders. There is a big leap in smoking from middle school to high school, close to twice the rate. The Youth Tobacco Survey provides essential information for prevention efforts including exposure to second hand smoke and media effects on youth.

The 2005 New Mexico YRRS specifically asks if the respondent smoked cigarettes during the past 30 days. The results showed that 25.7% of high school students identified themselves as current smokers; a 4.5% decrease since 2003.

New Mexico had the highest rate of cigar smoking within the previous 30 days. New Mexico had the highest rate among girls (15.6%), and the second highest rate among boys(25.7%).

Smokeless tobacco was used by 1.5% of females and 14.5% of males, similar to the national rates of 2.4% for females and 14.5% for males.

Fifty-six percent of youth reported being exposed to secondhand smoke during the past seven days. This was five percent less than 2003 results, though the difference was not statistically significant.

Current smokers were less likely to get good grades (mostly A's and B's than non-smokers (50.5% vs. 76.5%). They were less likely than other students to try to do their best work (36.4% vs. 54.2%) and to plan to attend college (61.7% vs. 80.7%). They were more likely than other students to skip school (23.3% vs. 7.6%) to come to school without paper (12.5% vs. 6.2%), and to fail to complete their homework (22.7% vs. 14.0%).

The percent of youth with "Sometimes" or "Often" not enough food to eat are significantly more likely to smoke than youth with "Enough" food to eat.

The NM Department of Health Tobacco Use Prevention and Control (TUPAC) program is a comprehensive, evidence-based public health program aim at reducing the health and economic burden caused by tobacco. In partnership with the Centers for Disease Control and Prevention, the program serves as a statewide resource to assist communities, schools and organizations in promoting health, tobacco-free lifestyles and reducing tobacco-related illnesses. TUPAC has developed a strategic five year plan to address Tobacco related Disparities. This plan includes: Quarterly Meetings of Implementation Committee, Workgroups for each of the goals established, Prioritization of goals and strategies for Year one, Dissemination and marketing of Plan, Progress in data collection among African Americans & Lesbian Gay Bisexual and Transgender Communities (LGBT), Aligning more contractor activities with strategic plan, Directing more funding toward disparities work, Continued monitoring by Implementation Committee, Address remaining goals and strategies in the plan and Continue to monitor progress and reassess direction.

The TUPAC program is offering free nicotine patches or gum to tobacco users from New Mexico who enroll in the "Quit for Life" program at 1-800-QUIT NOW, New Mexico's free tobacco help line.TUPAC also provides various educational materials currently available on the DOH intranet site that can be used to inform the public about the availability of the free services at 1-800-QUIT NOW. A strong interest in quitting is currently developing among tobacco users, in preparation for the Dee Johnson Clean Indoor Air Act which went into effect on June 15, 2006.

/2009/there is no new information to report for 2007//2009//

/2010/Current cigarette smoking among New Mexico high school students decreased significantly from 30.2% in 2003 to 24.2% in 2007. The prevalence of smoking before age 13 also decreased significantly during this time period, from 24.7% in 2003 to 18.0% in 2007. However, the percentage of youth using smokeless tobacco (chewing tobacco, snuff, or dip) has increased (8.8% in 2003; 8.5% in 2005; 11.8% in 2007). There were 18.9% of students who report using cigars, cigarillos, or little cigars in the last 30 days, which makes New Mexico the highest among YRBS states. Source: New Mexico Youth Risk and Resiliency Survey (YRRS) 2007//2010//

IV. Priorities, Performance and Program Activities

A. Background and Overview

The Title V Program uses a system approach that begins with a needs assessment and identification of priorities. It is expected the process will culminate in improved health outcomes for the target population. In 2005, the State agency conducted a comprehensive needs assessment to identify state MCH priorities. The State then developed state performance measures to monitor the success of their efforts to arrange programmatic and policy activity around these priorities.

The needs assessment was population-based and community-focused. The assessment issues were organized into three categories: 1) A review of selected Title V MCH specific performance measures and health indicators by population group, seeking input on what factors needed to be addressed to improve overall performance on the indicators and to address known gaps, disparities or barriers or build on strengths, 2) A review of access to and use of recommended primary, preventive and specialty care.

Children with special health care needs were one focus of access to specialty care. The assessment was organized around 3 MCH populations: maternal and infant health in terms of women's health in pre-conceptional, prenatal and post-partum periods and infant health; child health ages 0-14, and youth health ages 15-21. This section of the assessment included the dimensions of community-based systems and the network of partnerships. In addition there were 2 topics representing cross cutting concerns: fathers and families; and MCH issues regarding immigrants. The assessment was data-driven. The MCH Epidemiologist, Susan Nalder, compiled a data book using many various sources of population based data, program and selected studies or review of literature. This extensive data collection effort resulted in the provisional NM MCH Data Book. The State reviewed the data at the State Agency level. Instead of assessing all of MCH, the State chose to assess certain aspects of MCH that were particularly troublesome for New Mexico.

Using the pyramid process of prioritization and a review of the State's performance during the last 5 years, a group of State-level Program Managers and the Medical Director chose a list of 10 priorities as a framework of the assessment. To include the community and other stakeholders in the process of the development of state performance measures, the State MCH Program Managers then organized a series of town meetings in the four quadrants of the state. The assessment took place in four public health district sites in March 2005: Santa Fe, Albuquerque, Roswell and Las Cruces. Stakeholders invited included other state agencies, sister programs within the MCH state agency, county health offices, providers and facilities serving MCH populations, professional organizations, community-based and advocacy organizations, and the public. Each facilitated assessment exercise lasted 7 hours with 2 hours for formal presentations by FHB staff and 5 hours for soliciting input. The assessment focused on ten health topics. Each topic could become a state performance measure if the assessment indicated the need. Conclusions of the assessment were used to finalize the priority needs.
While several of the State performance measures were maintained, some were traded for new measures focusing on identified needs.

The priority health status problems of the MCH and CYSHCN populations are attributed largely to problems associated with poverty, working families with too few resources, no universal health coverage and its related issues of access to/use of primary care, health risk behaviors associated with stresses of poverty, and a high proportion of the state's counties not having health counseling for those who have problems with substance abuse. The assessment concluded that unemployment increased and the overall poverty performance did not improve. The assessment indicated that health gaps and disparities are seen consistently among teens, parents with only a high school education or less, and single parents. These characteristics translate into greater proportions of health risk behaviors, and lower access to and use of primary preventive care or

specialty care.

Although the state made progress in reducing the proportion of the population that has no health insurance, critical gaps persist. There is a significant challenge in assuring access to care for the working poor and immigrant families. Male involvement was recognized as a critical factor in the health of children. While the infant mortality rate, the neonatal and post neonatal mortality rate remained lower than the national rate, disparities were still observed. An estimated 30% of new mothers had positive behaviors with respect to the factors in the Healthy Birth Index, which indicated the need to raise prenatal health to a state priority. Home visiting and preconception health education were suggested as evidence based strategies.

Some strengths identified were that more children received Medicaid services although the risk of gaps in coverage may have increased. Medicaid has made significant progress, increasing the number of children served by increasing the reimbursement schedule and recruiting additional dentists who would accept Medicaid. The number of women receiving dental services during pregnancy was maintained in 2004.

Challenges remain in first trimester prenatal care as New Mexico, lagging behind the U.S. at twice the percent for beginning, inadequate use, childhood overweight, and hunger. Twelve percent of parents surveyed indicated their children were not always safe at home and fifty percent weren't safe in their neighborhood. The number of reported domestic violence cases and the number reported with children at the scene increased from 1999-2003. Unintentional injury caused almost half the deaths in children and youth 1-24 yrs.

/2007/FHB conducted a gap analysis this year to clarify where gaps existed within the Bureau and as they relate to Title V programs. Twenty-one topics issues emerged. Specific recommendations, steps to address them and costs were defined. Further analysis and planning resulted in prioritizing the top four priorities. The resources needed that exceed current resources were identified. Lastly the process and activities that will lead to outcomes were identified.//2007//

/2008/Activities by FHB and its partners resulted in many accomplishments including: 1) Expanded newborn genetic and hearing screening and related outreach activities, 2) Continued infrastructure building and community outreach for CYSHCN including expansion of peer-mentoring programs, 3) Passage of the Child Helmet Safety Act, 4) Publication of the report "The Economic Cost of Teenage Childbearing and Parenting in New Mexico: New Estimates", and 5) Passage of House Bill 613 safeguarding a nursing Mother's right to use a breast pump in the workplace.//2008/

/2009/The 2008 Legislative Session resulted in several bills and funding decisions that impact the Title V population. These are listed in the "State Priorities" section.//2009//

/2010/Breastfeeding rates continue to remain higher in New Mexico than the nation as the result of various breastfeeding campaigns statewide with the support of WIC and the Families First program. Additionally, the Breastfeeding Task Force has successfully banned the dissemination of formula gift packs that recent mothers would receive upon hospital discharge from ten hospitals in New Mexico.

In 2008, 82% of children had immunization coverage in the state and 30% of children received a developmental screening, compared to almost 20% nationwide due to various MCH efforts statewide.

In an effort to improve male involvement in family planning and fatherhood, the South Valley Male Involvement Project was created in Albuquerque that provides educational services to increase young men's knowledge and skills in addressing their reproductive

health needs.

Results from the New Mexico YRRS 2007 show that NM youth have decreased certain risk factors and have higher rates of physical activity than the rest of the nation. As mentioned in the state priorities section, statewide efforts continue to prevent obesity in adults and children.//2010//

B. State Priorities

NEEDS ASSESSMENT GENERATES PRIORITIES LIST

The needs assessment from 2005 was reviewed and found to be consistent with policy, the evidence gathered through the needs assessment process and the direction of programs at the community level. The Title V Programs studied the data from the Title V Performance Measures, the DPH Strategic Plan, and the new NM MCH Data Book and as well as the the information obtained in the needs assessment to develop the priorities of the State for the next 5 years. The Title V staff also analyzed the capacity and resource capability of the Title V Program. Program expenditures for over the last 8 years were analyzed to note funding trends, how funds were spent within the framework of the MCH Pyramid and whether the funding was appropriately distributed to meet the needs identified in the assessment. The MCH management team brainstormed about the solutions to be implemented where possible, given current funding realities. Funding for the program had not been increased significantly for 8 years. Resources were scarce and reallocation of resources was difficult at this time, however, a map for action was determined for future funding opportunities and grants.

The three priority areas that the Family Health Bureau is focusing on are: Promoting healthy families, 2) Promoting births to healthy families and 3) working to affect a reduction intentional and unintentional injury. In promoting healthy families, our focus is on raising healthy children by:

Improve access to and use of health & health related services for all MCH population groups: Reduce barriers and disparities to accessing community-based health and health related services for women, children and youth. Reduce medical services funding gaps for pregnant women and children in NM, such as those who are non-Medicaid eligible, children with orthopedic/rehabilitative needs, and children in need of catastrophic medical funding such as organ transplants.

Promote positive youth development experiences with emphasis on building personal & social assets at the family, school and community levels. The evidence base for this priority has shown that these strategies can work to reduce the proportion of youth who engage risk behaviors that may have life --long consequences.

Strengthen the role of males in MCH through promotion of effective initiatives in healthy fatherhood and in reproductive health through male involvement strategies:
Expand male involvement programs in state Expand primary prevention home visiting services to teen parents and first-time parents statewide.

Promoting healthy weight and physical fitness among parents and their children.
Expand parent education of healthy feeding relationships Change the school nutrition environment, focus on competitive foods Expand nutrition intervention for children at risk of overweight and those who are obese

Establish an infrastructure to support and monitor transition services for adolescents with special health care needs. Strengthen state and local efforts across sectors that work to assure a transition with continuity of access to health care and other essential services

Monitor the health of immigrants across the MCH population groups Collaborate closely with the NM Border Health Office of the DOH Use data from the national survey of child health to understand and respond to critical needs To increase births to healthy families, Title V will focus on these priorities
Improve indicators of health in the preconceptional and perinatal periods across all levels of the Title V MCH pyramid Expand services to support women's efforts to quit smoking and to avoid use of alcohol-related risks of pregnancy Expand women's access to folic acid in the preconceptional and perinatal periods Increase the proportion of women receiving adequate prenatal care.
Decrease unintended pregnancies and chlamydia among teens Expand effective strategies to avert unintended pregnancy among teens including educational and clinical family planning services Expand funding for chlamydia treatment To affect a reduction of intentional injury (violence in families) and unintentional injury:
Reduce indicators of violence affecting the MCH population with focus on selected issues Strengthen ongoing initiatives to reduce the risk of children being exposed to/witnessing violence Monitor confirmed cases of child abuse/neglect; confirmed cases of abuse, neglect and exploitation among adults; domestic violence Reduce the proportion of women who report physical abuse in 12 months before pregnancy and during pregnancy, through working with health care providers and targeted home visiting services to families at risk
Reduce rates of fatal & non-fatal unintentional injury among children and teens Strengthen statewide programs to prevent motor vehicle crash injuries and fatalities Strengthen safety in the home through educational initiatives, home visiting and other initiatives

These priorities are in sync with the Department's priorities of reducing teen suicide, reducing teen pregnancy, improving the weight of adults and children, improving access to medical and dental health services in agency-funded primary care centers, improving access to WIC, Family Planning, Families FIRST, and Children's Medical Services, increasing the number of primary health care and emergency medical professionals supported or obligated per year and working in underserved areas, reducing the percentage of Medical and Dental provider positions vacant over 6 months in community-based health centers, increasing the number of children screened for sealants by the DOH sealant program, and improving access for school age children by implementation of 34 new school based health centers. The statewide needs assessment exercise revealed that Regional and Local health entities of the DOH and its partners found these priorities to resonate strongly with their needs assessment efforts. In addition the assessment revealed significant work being done, across sectors, to address many of these priorities.

PRIORITIES LIST VS. TITLE V CAPACITY AND RESOURCE ALLOCATION INCREASING ACCESS TO AND USE OF HEALTH CARE:

Access to health care involves Title V serving on the EPSDT Steering Committee; working to improve developmental screening of children; promoting immunizations, and case management to use scarce resources well. Data indicates that as children grow older, their well child visits decline and physicians do not do developmental screening as they should. Lack of funding does not mean that Title V cannot work to affect change. Direct Services that need expansion are chlamydia treatment, prenatal care, nutrition interventions around obesity such as counseling for children at risk of overweight or obesity. Enabling services needing focus include: access to community-based health and health related services for women, children and youth; reduction of medical services funding gaps for children in NM, Youth development, male involvement, prenatal care and parent education. Infrastructure services should focus on community based services development for populations that experience health disparities, including male involvement, and mental health. Population based services should focus on: a method to monitor and track confirmed cases of abuse of pregnant women as well as methods to reduce family violence. The annual budget is increasingly spent on provision of direct services to the MCH population. The list of priorities, while it is imperative that we provide new services such as these, the MCH budget has not increased significantly since 1997. An effort will be made to restructure the MCAF Section to focus on the priorities above for expansion of home visiting, male involvement through Family

Planning, and Youth development strategies. As a new Medical Director will be hired this year, the emphasis on violence reduction will be a primary emphasis for that position. Resources for prenatal care, coordination with the WIC Program can change resources to focus on the folic acid component of prenatal care and an emphasis on reduction of smoking and drinking among women of childbearing age. Each of the priorities above ties to a State Performance Measure for New Mexico.

New State Performance Measures will be monitored closely to see if they indicate any changes in the prevalence of these issues. If these steps are taken, the hope will be that the level of low birth weight in the State will be reduced as will perinatal, infant, neonatal, post neonatal, and child morbidity and mortality. Department of Health

/2007/The following performance measures have been adopted this year by Public Health. These measures include all the state performance measures, breaking some into more discrete priorities. Their adoption reiterates the commitment of public health to the state performance measures.

1. Increase the percentage of newborns screened and confirmed with condition(s) mandated by their newborn screening programs who receive appropriate follow up

2. Increase the percent of children with special health care needs age 0 to 18 years whose families partner in decision making at all levels and are satisfied with the services they receive.

3. Increase the percent of children with special health care needs age 0 to 18 who receive coordinated, ongoing, comprehensive care within a medical home.

4. Increase the percent of children with special health care needs age 0 to 18 whose families have adequate private and/or public insurance to pay for their services

5. Increase the percent of children with special health care needs age 0 to 18 whose families report the community-based service systems are organized so they can use them easily.

6. Increase the percentage of youth with special health care needs who received the services necessary to make transition to adult life.

7. Decrease the rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children

8. Increase the percentage of mothers who breastfeed their infants.

9. Increase the percentage of newborns who have been screened for hearing impairment before hospital discharge

10. Reduce the percentage of children without health insurance

11. Increase the percentage of Medicaid eligible children who have received a service paid by the Medicaid Program

12. Increase the percentage of very low birth weight live births

13. Increase the percentage of very low birth weight infants delivered at facilities for high-risk deliveries and neonates

14. Increase the percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.

15. Increase the number of counties adopting the conceptual framework of an Assets-Resiliency model when working with youth

16. Increase the percent of first newborns/moms receiving support services/parenting through community home visiting/support programs.

17. Reduce unintended pregnancy in New Mexico

18. Increase the percentage of mothers who achieve all criteria of the Healthy Birth Index

19. Increase male involvement

20. Reduce the percentage of children witnessing violence

21. Reduce the proportion of new mothers who report being physically abused during pregnancy

22. Increase the number of 6th grade students receiving abstinence education services

23. Increase the proportion of students, in schools where there is an abstinence program, who maintain or increase intent to delay sexual activity.//2007//

/2008/PHD supplement performance measures are in addition to the NM DOH Strategic plan measures. The DOH FY08 Strategic Plan included 7 measures addressing FHB and PHD priorities and programs: Increase immunizations for children and adolescents, reduce teen pregnancy, reduce child and adolescent obesity and diabetes in all populations, reduce suicide among youth, reduce tobacco use, expand healthcare for school-age children and youth through school-based health services, and improve access to preventive and restorative oral health services provided to children, low income rural populations and people with disabilities.

Program Area 2: Public Health

Objective 1: Increase the capacity of the Health Department to decrease disparities Performance Measures. The State Priorities include the 18 National Performance Measures, and the following seven State Performance Measures:

SPM 01: Increase the number of counties and tribal entities implementing positive youth development strategies defined by 6 key criteria.

SPM 02: Increase the percent of first newborns/moms receiving support services/parenting through community home visiting/support programs.

SPM 03: Reduce unintended pregnancy in New Mexico to less than 30 percent of births

SPM 04: Reduce the number of children witnessing violence (exposed to domestic or sexual violence) as expressed by percent of children present at a domestic violence scene.

SPM 05: Increase the proportion of women who report having all six criteria of the NM Healthy Birth Index

SPM 06: Reduce the proportion of new mothers who report being physically abused by husband or partner during pregnancy

SPM 08: Screen infants for congenital syphilis

Note that SPM 07 has been retired: "Reduce the proportion of children age 2-5 years who are at risk of overweight and who are overweight.

There are two additional priorities not included in the NPMs or SPMs:

1. Percent of Commodity Supplemental Food Program (CSFP) participants served through the CSFP program. FY06/FY07 Target = 100% of caseload assignment.

2. Percent of WIC participants served through the Supplemental Nutrition Program for Women Infants and Children. FY06/FY07 Target = 100% of caseload assignment.//2008//

/2009/The FY09 strategic plan for New Mexico includes 19 priorities, of which 13 directly impact the MCH population:

1. Expand Healthcare Access in Rural and Underserved Areas through Telehealth Services.
2. Increase Awareness about Health Disparities.
3. Increase Immunizations for Children and Adolescents.
4. Reduce Teen Pregnancy.
5. Decrease the Transmission of Infectious Disease Cases and Expand Services for Persons with
6. Infectious Diseases.
7. Reduce Child and Adolescent Obesity and Diabetes in All Populations.
8. Reduce Suicide Among Youth.
9. Reduce Tobacco Use.
10. Expand Healthcare for School-Age Children and Youth Through School-Based Health Services.
11. Improve Access to Preventive and Restorative Oral Health Services Provided to Children, Low income Rural Populations and People with Disabilities.
12. Expand Access to Vital Records.
13. Enforce "Zero Tolerance" of Abuse, Neglect or Exploitation of Children, Seniors and Vulnerable Adults.

The 2008 Legislative Session resulted in several bills and funding decisions that impact the Title V population. They are indiciative of state priorities and of the political will to address them:

HB33, Domestic Violence Treatment Fund Uses
allows referrals to and voluntary participation in domestic violence offender programs without a court order.

HB89, Physician Assistant Requirements amends
existing laws to include physician assistants within the definitions and provisions of health care providers.

HB167, Birthing Workforce Retention Fund provides
medical malpractice premium assistance to certified nurse midwives or physicians who can show that at least half of their patients are on Medicaid or receive indigent care. Received $44,000 in funding.

HB236, Off Reservation Native American Health
creates a commission in Bernalillo County to explore off-reservation Native American health care needs. Received $60,000 in funding.

HB364, Children's Mental Health & Disabilities Act amends
the Act to clarify when the use of restraints is appropriate for children with mental health and/or developmental disabilities.

HB546, Tobacco Settlement Fund Programs appropriates an

additional $1,750,000 to the DOH for smoking cessation and prevention programs, if the revenue to the Tobacco Settlement Program Fund exceeds the appropriations made from the fund in the General Appropriation Act of 2008.

SB68, Increase Domestic Violence Penalties increases penalties for three or more batteries or aggravated batteries against certain household members.

SB127, Waive Licensure Fees for Medical Doctors permits the NM Licensure Board to waive licensure fees to recruit and retain medical doctors for practice in the state.

SB178, Breast Cancer Awareness License Plates allows issuance of a special license plate that commemorates breast cancer awareness .

SB129, Healthy New Mexico Task Force establishes a task force to devise a strategic plan for implementing disease prevention and chronic condition and chronic disease management measures.

Funding:
$220,000 - To enhance the telehealth efforts of the Envision, Reach, and Suicide Prevention programs

$550,000 - Electronic Medical Records and Health Information Exchange

$1,000,000 - Targeted Childhood Immunization Efforts

$500,000 - Funding Parity for School Based Health Centers (to equalize funding between older SBHCs and new ones)

$417,600 - Nurse Advice Line Health Services

$750,000 - Tuberculosis Program Increased Costs (to meet greater demand as TB incidence and complexity increases)

$100,000 - Contraceptives Cost Increase

$289,200 - Billing & Electronics Health Records

$210,000 - Relocation of Public Health Pharmacy

$500,000 - Breast & Cervical Cancer Program Administration (to meet increasing demand for no-cost B&CC screening)

$50,000 - Establish Healthy New Mexico Task Force

$44,000 - Birthing Services Providers - Assistance with Malpractice Premiums

$60,000 - Native American Health Commission//2009//

/2010/Obesity Initiative

The New Mexico Health Secretary has recently reported that the state needs to increase its efforts to prevent obesity in the state. Current efforts include nutrition rules for school vending machines and restrictions on the types of foods that are sold in schools, as well as various programs that are geared towards increasing physical activity and nutrition intake. Governor Bill Richardson has made obesity prevention a priority in his administration.

The U.S. Centers for Disease Control and Prevention recently awarded the New Mexico Department of Health (DOH) a $2.4 million grant to address childhood obesity in the state. The DOH will receive about $600,000 each year for four years to fund physical activity and nutrition programs that motivate children to eat healthier and move more. DOH will use the funding to strengthen collaborative anti-obesity efforts across state departments, develop consistent educational messages for the public and replicate a successful anti-obesity project in Las Cruces. The Department will also provide small grants to community organizations that have been successful in improving nutrition and increasing physical activity for children.

Additionally, the DOH launched a community-wide project last year entitled Healthy Kids Las Cruces, which enhances community efforts to motivate children, teenagers and families to eat healthier and be more physically active. DOH leads the project, which involves local and state government, education, health care, social services, agriculture, non-profit organizations, foundations and businesses. They plan to expand the initiative statewide and they are working on developing a program in Chaves County and in tribal communities.

Healthy Kids Healthy New Mexico is another way the DOH tries to reduce obesity rates. They collaborate with state and local agencies and community partners across New Mexico to help communities develop polices and programs that support families in developing healthy eating and physical activity habits. State-sponsored programs also include cooking classes for children and diabetics, activities for people with arthritis and nutrition education through Women, Infants and Children.

The 2009 Legislative Session resulted in several bills and funding decisions that impact the Title V population. They are indicative of state priorities and of the political will to address them:

The New Mexico legislators continued their efforts in 2009 to improve the lives of children through increasing their opportunities to receive public benefits, improving their chances at success in moving from state custody to independent living and increasing their contact with supportive social workers.

As part of these efforts, the legislature passed Senate Bill 137 (Chapter 186) to ensure that the income of a legal guardian of a child no longer will be added to the equation in determining whether a child is entitled to TANF benefits. The bill was aimed at increasing the number of adults able and willing to care for a child, including foster parents and grandparents who raise a child.

Senate Bill 57 (Chapter 32) makes non-custodial parents liable for medical assistance provided during any period in which the parent's children are provided cash assistance. It also requires parents responsible for the support of minor children to provide health and dental insurance or to provide cash support for care when this insurance coverage is not available.

The legislature focused this year on the key areas of health care delivery, private health insurance, public coverage programs and public health. Included among the health care delivery bills are several that expand or clarify the scopes of practice for health

professionals, including complementary and alternative health care providers, chiropractors, persons providing magnetic resonance and sonography services and certified nurse practitioners.

To address the health coverage needs of affected families of children with autism, the legislature passed Senate Floor Substitute for Senate Public Affairs Committee Substitute for Senate Bill 39 (Chapter 74), which mandates coverage for diagnosis and treatment for autism spectrum disorder. In addition to defining autism spectrum disorder, the bill mandates that speech therapy, occupational therapy, physical therapy and applied behavioral analysis be covered. //2010//

C. National Performance Measures

Performance Measure 01: *The percent of screen positive newborns who received timely follow up to definitive diagnosis and clinical management for condition(s) mandated by their State-sponsored newborn screening programs.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	100	100	100	100	100
Annual Indicator	100.0	100.0	100.0	100.0	100.0
Numerator	18	16	17	15	30
Denominator	18	16	17	15	30
Data Source					Children's Medical Services program
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	100	100	100	100	100

Notes - 2008
Confirmed cases needing treatment were:

Phenylketonuria
Congenital Hypothyroidism
Duarte-Galactocemia
Sickle Cell Disease
Hemoglobin=FD/G
Congenital Adrenal Hyperplasia
Cystic Fibrosis
Amino Acids
Acylcarnitines
Hemoglobin Traits

Notes - 2007

Source: Children's Medical Services program, New Mexico Department of Health.

Notes - 2006
See note for 2005.

a. Last Year's Accomplishments
July 2008-June 2009

Direct: 8 outreach metabolic clinics include long term follow-up of adults after age 21 with metabolic disorders, Care coordination provided to families by community based CMS social workers.

Enabling: Long-term services begin with diagnosis through life-span Positive case referred for care coordination by CMS social worker, overseen by CMS Newborn Screening Nurse consultant. Follow-up system consists of Oregon State Public Health Lab, Oregon State Specialists, CMS Nurse Consultant, UNM specialists, CMS social worker, UNM genetic counselor, metabolic nutritionist.

Population-Based: Preventive intervention includes working with 34 birthing facilities & midwives to improve collection of newborn screens. Disease prevention through long-term follow-up program: CMS nurse consultant, CMS social workers, specialists. Public education includes information on Newborn screening: brochures, waiver translated in Spanish. Newborn Screening website accessible for both Public & professional staff & updated yearly.

Infrastructure Building: Activities: training, educational materials & support to Labs, OB staff who collect Blood spots. Each facility receives updates monthly of practice profile, a QA tool updating them on their progress. Educational materials are provided to physicians, nurses, midwives, social workers. Database linkage between newborn genetic screening, hearing screening program & vital records, electronic birth certificates are being strengthened.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Monthly Memo's sent out with practice profile, informing facilities on their performance on newborn screens submitted.			X	
2. Continued Development of standard/guidelines for expanded screening. Collaboration of a data system to include Newborn screening, newborn hearing, vital records and birth defects.				X
3. Monitor implementation of a long-term comprehensive Follow-up system. Which will include CMS Nurse Consultant, CMS social workers, Medical specialists, PCP's, Family and Oregon State Public Health Lab				X
4. Working with facilities on a QA plan, for education, and training of staff ongoing.				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

July 2008-June 2009

Direct: 8 outreach metabolic clinics include long term follow-up of adults after age 21 with metabolic disorders, Care coordination provided to families by community based CMS social workers.

Enabling: Long-term services begin with diagnosis through life-span Positive case referred for care coordination by CMS social worker, overseen by CMS Newborn Screening Nurse consultant. Follow-up system consists of Oregon State Public Health Lab, Oregon State Specialists, CMS Nurse Consultant, UNM specialists, CMS social worker, UNM genetic counselor, metabolic nutritionist.

Population-Based: Preventive intervention includes working with 34 birthing facilities & midwives to improve collection of newborn screens. Disease prevention through long-term follow-up program: CMS nurse consultant, CMS social workers, specialists. Public education includes information on Newborn screening: brochures, waiver translated in Spanish. Newborn Screening website accessible for both Public & professional staff & updated yearly.

Infrastructure Building: Activities: training, educational materials & support to Labs, OB staff who collect Blood spots. Each facility receives updates monthly of practice profile, a QA tool updating them on their progress. Educational materials are provided to physicians, nurses, midwives, social workers. Database linkage between newborn genetic screening, hearing screening program & vital records, electronic birth certificates are being strengthened.

c. Plan for the Coming Year
July 2009 -- June 2010

Direct: UNM will provide outreach clinics and follow-up to clients, in areas across New Mexico that require their services. Social workers for Children's Medical Services will receive referrals form the Genetic Newborn Screening Program for care coordination.

Enabling: The Newborn Screening program will work with UNM metabolic team and Sickle cell counsel in strengthening our Long-term follow-up process. Our programs will meet quarterly to review referred cases for continuity of care. To ensure families or clients receive optimal care.

Population-Based: Preventive intervention includes referring of clients to specialists, case management, and follow-up on presumptive positive cases to ensure that confirmatory testing is done. Infrastructure Building: Quality assurance through Monthly Practice profile reports to each birthing facility and Midwives. Updating facilities and Midwives on current events on Newborn Screening by monthly memos. Disease prevention achieved through Placement of Newborn screening kits in Public Health areas to ensure families have access to forms for repeat or second screens.

Performance Measure 02: *The percent of children with special health care needs age 0 to 18 years whose families partner in decision making at all levels and are satisfied with the services they receive. (CSHCN survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance	2004	2005	2006	2007	2008

Data					
Annual Performance Objective	46	48	48	52	55
Annual Indicator	46	53.2	53.2	53.2	53.2
Numerator					
Denominator					
Data Source					http://mchb.hrsa.gov/cshcn05/SD/newmexico.htm
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	55	55	55	55	55

Notes - 2008
Please see notes from 2006 and 2007.

Notes - 2007
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM02 indicator for both the 2001 and the 2005-2006 CSHCN survey.

Notes - 2006
Source: 2005/2006 National Survey of Children with Special Health Care Needs New Mexico Chartbook Page

http://www.cshcndata.org/Content/StatePrevalence2005.aspx?geo=New%20Mexico

a. Last Year's Accomplishments
July 2007 -- June 2008

Direct: Efforts continued to expand medical home concept in New Mexico, with the discussion of the concept continuing at professional meetings and conferences. On-going family-centered approach in care coordination, included involvement of youth in transition planning for State

CYSHCN Program is utilized.

Enabling: CMS sustained family participation in MCH Collaborative, referrals to PRO, NM Interagency Coordinating Council, Newborn Hearing Screening Advisory council, AMCHP Conference, and the Healthy Transition New Mexico Coordinating Council. PKU Support Group continued more informally to provide advocacy for their families. CMS Program contracted with Education for Parents of Indian Children with Special Needs (EPICS) to provide staff training, parent advocacy training, and to ensure that New Mexico families are represented at AMCHP Conference. CMS also sponsored and presented at a Parent Leadership Training through EPICS. Participants were trained in advocacy skills, finding resources, youth transition and many other topics during the 3-day workshop.

Population-Based: Sustained family participation in MCH Collaborative, referrals to PRO, NM Interagency Coordinating Council, AMCHP Conference, and CMS efforts to address integration of Medical Home, as well as Healthy Transition New Mexico Council Initiatives. Contacts were re-established between CMS and Social Security Disability Determination Unit to discuss the need for generating SSI Reports to be sent to CMS who can make referrals to PRO. Family Organizations were invited to provide input into CYSHCN Program Activities during a meeting held, primarily utilizing information from previous Title V Performance Measures submitted. Referrals to/from Parents Reaching Out continued. A newly-formed chapter of Hands and Voices, which supports parents with deaf and hard of hearing children, started in NM. Three representatives were invited to join the Newborn Hearing Screening Advisory Council.

Infrastructure Building: CYSHCN Program sustained partnerships with family organizations, and sought input into all Program areas involving them in decision- making; and worked with partners to identify statewide strategies to address the six CYSHCN performance measures. The Title V Program contracted with EPICS and collaborated with other family organizations to provide needed training and support to families. CMS program manager worked with AMCHP in Emergency Preparedness by developing a comprehensive plan for CYSHCN addressing family needs. Included in the planning was a family from Yale. CMS met with Family Organizations to discuss ways to improve upon efforts to ensure families partner in decision-making at all levels and are satisfied with the services they receive.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Establish contracts with family organizations and/or selected family members to assure family involvement in decision making.			X	
2. Family organizations will provide education & training to CMS social workers and other providers on family involvement practices.		X		
3. Establish new or utilize existing councils to review CYSHCN survey outcomes and to develop plan for improvement.				X
4. Analysis of NM specific data in national survey of CYSHCN to identify key issues to improve performance				X
5. Recruit parent representation onto the Newborn Genetic Screening Advisory Council			X	
6.				
7.				
8.				
9.				
10.				

b. Current Activities
July 2008--June 2009

Direct: Continue efforts to expand medical home concept by discussing the concept at meetings/conferences. Continue family-centered approach in care coordination, including involving youth in transition planning.

Enabling: Ensure family participation in MCH Collaborative, NM Interagency Coordinating Council, Newborn Hearing Screening Advisory Council, AMCHP Conference, and Statewide Transition Coordinating Council. Contract with family organizations to ensure families partner in decision-making at all levels. CMS is sponsoring the Parent Leadership Training through EPICS. A few participants from last year's Institute are trainers at this year's Institute. The NBHS program sponsored a parent to attend the National EHDI Conference.

Population-Based: Family Organizations provide input into Program Activities during meetings. CMS staff met with Social Security Disability Determination Unit to discuss the need for SSI Reports to be sent to CMS who can make referrals to PRO. Pending resolution of HIPAA issues, CMS expects to begin receiving reports again. Family Organizations are invited to provide input into CYSHCN Program Activities utilizing information from previous Title V Performance Measures submitted.

Infrastructure Building: CMS program manager is on the CYSHCN Integrated Services board for the Navajo Nation with a focus on youth transition. The NBHS coordinator is on the board of the Family to Family Health Information Center with PRO.

c. Plan for the Coming Year
July 2009 -- June 2010

Direct: Continue efforts to expand medical home concept in New Mexico, with the discussion of the concept continuing at professional meetings and conferences. Continue on-going family-centered approach in care coordination, including involvement of youth in transition planning for State CYSHCN Program. Continue referrals to family support organizations for family to family connections.

Enabling: CMS will sustain family participation in MCH Collaborative, NM Interagency Coordinating Council, Newborn Hearing Screening Advisory Council, AMCHP Conference, and the Statewide Transition Coordinating Council. CMS will meet with family organizations to define contracts to improve upon efforts to ensure that families partner in decision-making at all levels and are satisfied with the services they receive. Scope of work will include participation in local, State and National meetings/conferences, training for staff and families, and advisory role to CMS Program regarding policy.

Population-Based: Sustain family participation in MCH Collaborative, referrals to PRO, NM Interagency Coordinating Council, NBHS Advisory Council, AMCHP Conference, and CMS efforts to address integration of Medical Home, and Statewide Transition Coordinating Council Initiatives. CMS will recruit a parent representative to join the Newborn Genetic Screening Advisory Council. Family Organizations will be invited to provide input into CYSHCN Program activities during scheduled meeting.

Infrastructure Building: CYSHCN Program will sustain partnerships with family organizations, seeking input in all Program areas and involving them in decision-making. CMS will continue to meet with Family Organizations to discuss ways to improve upon efforts to ensure that families partner in decision-making at all levels and are satisfied with the services they receive. CMS Program will contract with family organizations to support these efforts. The CMS program

manager will continue to provide leadership with AMCHP in Emergency Preparedness for CYSHCN specifically addressing family needs.

CMS program manager will continue to participate on the CYSHCN Integrated Services board for the Navajo Nation focusing on youth transition. The NBHS coordinator will continue to participate on the board of the Family to Family Health Information Center with PRO.

Performance Measure 03: *The percent of children with special health care needs age 0 to 18 who receive coordinated, ongoing, comprehensive care within a medical home. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	46	48	50	52	43
Annual Indicator	45.4	41.6	41.6	41.6	41.6
Numerator					
Denominator					
Data Source					http://mchb.hrsa.gov/cshcn05/SD/newmexico.htm
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	43	43	43	43	43

Notes - 2008
Please see notes from 2006 and 2007.

Notes - 2007

Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions and additions to the questions used to generate the NPM03 indicator for the 2005-2006 CSHCN survey. The data for the two surveys are not comparable for PM #03.

Future performance objectives have been lowered to a more attainable level based on the most recent survey results.

Notes - 2006
Source: 2005/2006 National Survey of Children with Special Health Care Needs New Mexico Chartbook Page

http://www.cshcndata.org/Content/StatePrevalence2005.aspx?geo=New%20Mexico

a. Last Year's Accomplishments
July 2007-- June 2008

The CYSHCN Program coupled with provider and agency partners works to ensure that CYSHCN ages 0-18 receive coordinated, ongoing, comprehensive care within a medical home (CSHCN Survey). The 2005-2006 SLAITS reports that 41.6% of CYSHCN have a medical home.

Direct: The peer mentor program in Las Vegas was completed. The CYSHCN Director continued to provide guidance in the development of a peer-mentor program for the Navajo Nation which was slated to take place in FY '08 based on the Las Vegas model. This program assists YSHCN with transition from pediatric to adult medical care with a focus on integrating the medical home into the process.

Population-Based: The Newborn Hearing and Genetic Screening Programs continue to stress inclusion of the medical home during follow-up when an infant is identified through screening.

Infrastructure Building: CMS CYSHCN Program continued to work with partners to identify statewide strategies to address the six CYSHCN performance measures. CYSHCN and partners continued to provide input into the Medicaid redesign and the State Health Plan design. Healthy Transition New Mexico Council continued to address the inclusion of the medical home concept, thus assuring a smoother transition from pediatric to adult medical care coordination. The Title V Program contracted with EPICS and other family organizations to provide needed training and support to families regarding medical home, transition and family involvement in decision making.

An annual summit to address Early Period Screening, Diagnosis and Treatment (EPSDT) in New Mexico is held. The summit includes a discussion of medical home and the integral nature of the medical home in addressing EPSDT issues. Professionals as well as family members provide their expertise. The summit was convened by the Title V MCH program , in response to a request by the Children's Cabinet Secretaries from DOH, HSD, Public Education, Department of Aging, Department of Labor, and Department of Public Safety. There has been an additional hearing with parents continuing this discussion. The Asthma summit began in 2008 and stressed the importance of medical home as the standard of care for children and youth with asthma.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Develop peer mentorship program on the Navajo Nation	X			
2. Continue work with Children's Cabinet on EPSDT implementation project				X

3. Provide input on Medicaid redesign and state health plan				X
4. Asthma summit follow-up			X	
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
July 2008--June 2009

Direct: The CYSHCN Director continued to provide guidance in the development of a peer-mentor program for the Navajo Nation which was slated to take place in FY '08 based on the Las Vegas model. This program assists YSHCN with transition from pediatric to adult care with a focus on the medical home into the process. This program is on hold due to the loss of several key staff members and the economy. The State implemented a hiring freeze thus these position remain vacant. Also out of state travel is severely limited making implementation of this program even more difficult. The CMS social workers continue to attempt to connect clients to a primary care provider.

Population-Based: The Newborn Hearing and Genetic Screening Programs continue to stress inclusion of the medical home during follow-up when an infant is identified through screening.

Infrastructure Building: The Asthma summit was completed in 2009 Follow-up activities are on-going. Work continued with the Children's Cabinet in addressing the medical home concept and EPSDT compliance through the Early Childhood Action Committee. CMS and partners provide input regarding the Medical Home concept into the expanded Medicaid program and the State Health Plan. The Developmental Screening Initiative continues. CMS applied to HRSA for the Integrated Services grant which will emphasize medical home and youth transition along with the six core performance measures.

c. Plan for the Coming Year
July 2009 -- June 2010

Direct: Continue the development of a peer-mentoring program for the Navajo Nation based on the model developed in Las Vegas if staff is allowed to travel. The peer-mentoring program assists YSHCN with transition from pediatric to adult medical care with a focus on integrating the medical home concept into the process.

Population-Based: The Newborn Hearing and Genetic Screening Programs will continue to include the medical home during follow-up when an infant is identified through newborn screening. Continue follow-up in Regions on asthma protocols which emphasize link with medical home.

Infrastructure Building: Continue working with the Children's Cabinet in addressing the medical home concept as it relates to EPSDT compliance in New Mexico. CYSHCN and partners will continue to provide input regarding the Medical Home concept into the Medicaid redesign and the State Health Plan. The Title V Program will continue to contract with EPICS and other family organizations to provide needed training and support to families regarding medical home, transition and family involvement in decision-making. Continue working with Developmental Screening Initiative which provides telehealth training to primary care practices statewide and

includes PCP's, CMS social workers, and early intervention providers. If CMS receives HRSA funding for the Integrated Services grant a focus will be on enhancing medical home through co-location of CMS social workers in selected primary care practices throughout the state. The focus will be medical home and youth transition but all six core MCH performance measures will be integrated.

Performance Measure 04: *The percent of children with special health care needs age 0 to 18 whose families have adequate private and/or public insurance to pay for the services they need. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	60	62	70	70	59
Annual Indicator	57.4	56.6	56.6	56.6	56.6
Numerator					
Denominator					
Data Source					http://mchb.hrsa.gov/cshcn05/SD/newmexico.htm
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	59	59	59	59	59

Notes - 2008
Please see notes from 2006 and 2007.

Notes - 2007

Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM04 indicator for both the 2001 and the 2005-2006 CSHCN survey.

Notes - 2006
Source: 2005/2006 National Survey of Children with Special Health Care Needs New Mexico Chartbook Page

http://www.cshcndata.org/Content/StatePrevalence2005.aspx?geo=New%20Mexico

Future performance objectives have been lowered to a more attainable level based on the most recent survey results.

a. Last Year's Accomplishments
July 2007 -- June 2008

Enabling: Care coordination to 6,200 CYSHCN and school-age children not Medicaid eligible. CMS continued to assess insurance options for clients. PE-MOSAA's completed if eligible. Also the social workers assist clients to enroll in NMMIP and LIPP (Low Income Premium Plan) and the State Coverage Initiative (SCI) if eligible. Social workers assured that CYSHCN do not lose Medicaid benefits due to DRA requirements proving citizenship. The FIT program will continue to screen for insurance on all clients enrolled in the program.

Infrastructure Building: Monitor Governor's insurance expansion for children, the self-employed, small business owners. CMS will maintain representation on the Medicaid Outreach Committee. CMS maintains representation on the Advisory Board for the Family-to-Family Health Information Center. CMS w met with NMMIP to readdress uncovered pediatric diagnosis. The 2007 Legislature awarded CMS $500,000 additional funds. $300,000 was utilized to increase the number of children enrolled in NMMIP by 50 with an emphasis on children with unmet orthopedic needs. $100,000 was used to enhance services to the D/HH Community, $100,000 to the Blind and Visually Impaired Community. CMS monitored implementation of new laws mandating private insurance companies cover hearing aids for children and to cover autism. In addition the Medicaid reimbursement for hearing aids was increased from $400 to $ 1400 per aid. The Medical Director continued to participate in the Pediatric Council formed to address barriers in care for children with asthma. An Asthma summit was held statewide in 2007-2008. The summit included key stakeholders including DOH, IHS, the MCO's, UNM, rural community health care providers, school health, school based health clinics and resulted in a new pulmonologist from Presbyterian coming on board to provide services to CMS clients. CMS participated in the Medicaid Outreach Committee which meets quarterly. The Committee includes representatives from Medicaid, the MCO's, and Behavioral Health. The work of the committee is to increase enrollment statewide.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Provide care coordination to CYSHCN		X		
2. Expand coverage to children by enrolling onto NMMIP.				X
3. Work with the Commission for the Deaf and the Commission for the Visually Impaired to improve services to children in these communities				X
4. Continue work with the Pediatric Council to address coverage by Medicaid and the MCO;s for pediatric asthma				X
5. Continue participation on Medicaid Outreach Committee				X

6.				
7.				
8.				
9.				
10.				

b. Current Activities
July 2008 -- June 2009

Enabling: Continued to provide Care coordination to approximately 6,200 CYSHCN and school-age children who are not Medicaid/SCHIP eligible. CMS CYSHCN Program continued to provide assessment of insurance options for clients, and PE-MOSAA's to determine if the children or youth are eligible. Also the social workers assist clients to enroll in NMMIP and LIPP and SCI if eligible.

Infrastructure:: The CYSHCN Program enrolled 60 more children onto the NMMIP with an emphasis on children who have unmet orthopedic needs.

CMS continued to work with NMMIP to increase coverage for certain diagnoses.
The program continued its work with the Commission for the Deaf and the Commission for the Blind and Visually Impaired to improve services to children in these communities.
CMS continued to attend the Pediatric Council meetings to address the needs and improve the care of children with asthma in dialogue with Medicaid and the MCO's. The Asthma summit was completed in 2008. The CMS program continued to be represented on the Advisory Board for the Family-to-Family Health Information Center at Parents Reaching Out. CMS continued to explore eligibility requirements and gaps in coverage under the multiple plans under Insure New Mexico. CMS continued to work with CTH to address the unmet needs of non-Medicaid eligible children and youth with orthopedic needs. CMS continued to participate on the Medicaid Outreach Committee. Enrollment into SCI was frozen due to the economy.

c. Plan for the Coming Year
July 2009 -- June 2010

Enabling: Continue to provide Care coordination to approximately 6,200 CYSHCN and school-age children who are not Medicaid/SCHIP eligible. CMS CYSHCN Program will continue to provide assessment of insurance options for clients, and PE-MOSAA's to determine if the children or youth are eligible. Also the social workers assist clients to enroll in NMMIP and LIPP and SCI if eligible.

Infrastructure Building: The CYSHCN Program will continue to enroll 25 more children onto the NMMIP with an emphasis on children who have unmet orthopedic needs. The program has been able to enroll the majority of children with high cost conditions thus expects enrollment be able to focus on new referrals only.

CMS will continue to work with NMMIP to increase coverage for certain diagnoses. The program will continue its work with the Commission for the Deaf and the Commission for the Blind and Visually Impaired to improve services to children in these communities. The CMS Medical Director will continue to attend the Pediatric Council meetings to address the needs and improve the care of children with asthma in dialogue with Medicaid and the MCO's. The CMS program will continue to be represented on the Advisory Board for the Family-to-Family Health Information Center at Parents Reaching Out which is addressing insurance coverage for CYSHCN in the state.
CMS will continue to explore eligibility requirements and gaps in coverage under the multiple plans under Insure New Mexico. CMS will continue to work with Carrie Tingly Hospital to address the unmet needs of non-Medicaid eligible children and youth with orthopedic needs. CMS will

continue to participate on the Medicaid Outreach Committee and especially monitor enrollment efforts into the State Coverage Initiative which was frozen due to the economy. The stimulus package may be addressing the shortfall in the budget that maintains SCI.

Performance Measure 05: *Percent of children with special health care needs age 0 to 18 whose families report the community-based service systems are organized so they can use them easily. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	68	69	70	70	89
Annual Indicator	66.5	85.7	85.7	85.7	85.7
Numerator					
Denominator					
Data Source					http://mchb.hrsa.gov/cshcn05/SD/newmexico.htm
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	90	90	90	90	90

Notes - 2008
Please see notes from 2006 and 2007

Notes - 2007
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were revisions to the wording, ordering and

the number of the questions used to generate the NPM05 indicator for the 2005-2006 CSHCN survey. The data for the two surveys are not comparable for PM #05.

Notes - 2006
Source: 2005/2006 National Survey of Children with Special Health Care Needs New Mexico Chartbook Page

http://www.cshcndata.org/Content/StatePrevalence2005.aspx?geo=New%20Mexico

a. Last Year's Accomplishments
July 2007 -- June 2008

The 2005-2006 National Survey of Children with Special Health Care Needs report a rate of 85.7%. This exceeded the 2001 rate of 66.5 %. The new target will be set at 90%

Direct Health Care Services: Care coordination was provided by CMS staff and available to all CYSHCN and their families; strengthened linkages to early intervention services and the Part C program through increased child find activities with CYFD and pediatric practices; and maintain specialty clinics statewide. CMS sponsored 122 multi-disciplinary pediatric specialty clinics statewide. The clinic included: cleft lip and palette, pulmonary, neurology, dysmorphology genetics, renal and a Fetal Alcohol Syndrome clinic in Santa Fe County.

Population Based Services -- CMS CYSHCN Program and the CMS FIT Program worked with partners in statewide stakeholders meeting with the Early Childhood Action Network to address assurance of EPSDT screening for children and youth. These partners worked together to increase the identification and early referral to early intervention services for children with or at risk for developmental delays.

Infrastructure Building: The Title V Director continued as a designee to the Children's Cabinet, and continued to provide representation to the Early Childhood Action Network. Ms. Peacock, now Deputy Division Director for PHD, continued to serve in an advisory capacity to the Secretaries of the Departments of Health, Human Services, Aging and Children, Youth and Families in her work with the Children's Cabinet. The Title V Director continued to work with partners on NM Children's Report Card, including reporting on measures of children's health and transition to adulthood and employment. The Directors of Title V, CYSHCN and CMS FIT programs continued to work with key state leaders from state agencies, parents, early intervention programs, medical providers/pediatricians, the Interagency Coordinating Council non-profit agencies regarding EPSDT needs and plans resulting from the Developmental Screening Symposium to identify and address unmet EPSDT needs in New Mexico. Although the CYSHCN program, in cooperation with UNMH provides community based multidisciplinary pediatric specialty outreach clinics, there remains an ongoing challenge to retain and recruit specialists. This has required the program, UNM and their partners to begin a process of rethinking the delivery of services and how to best support the infrastructure in NM. The team explored changing the delivery of clinic services. The idea is to have the clinic overseen by specialists, with the majority of the services administered by mid-level professionals. While this is a major change, all parties are exploring this effort with a community-centered approach, thinking of the most helpful way to support community providers in this rural state. No clear decision was made at the time.

CMS collaborated with Environmental Epidemiology and convened the statewide asthma summit, a series of plans to action oriented meetings with key stakeholders from the public and private sector to create a comprehensive, multidisciplinary approach to pediatric asthma care for NM. Meetings were held in Albuquerque, Roswell and Santa Fe with a regional meeting in Gallup scheduled for the July 08 and a wrap up meeting in Albuquerque in September 08. A special follow-up meeting in Hobbs will take place in the fall of 08 in response to the high rates of

asthmas related care that was discovered. A new pulmonologist from Presbyterian hospital was recruited as a result of the Summit to provide more pulmonary clinics.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Provide care coordination to CYSHCN	X			
2. Sponsor 127 outreach specialty clinics statewide	X			
3. Continue work with partners to ensure EPSDT screening			X	
4. Provide representation to the Children's Cabinet and Early Childhood Action Network				X
5. Explore provision of services to children with asthma/asthma summit				X
6. Increase number of CYSHCN on NMMIP				X
7. Work with Secretary's office to address infrastructure for CYSHCN				X
8.				
9.				
10.				

b. Current Activities
July 2008 -- June 2009

Direct: Care coordination provided by CMS staff. Maintain 127 specialty multidisciplinary specialty clinics statewide.

Population-Based: Program continues to work with partners to assure access to EPSDT to increase identification and referral to early intervention services.

Infrastructure Building: Title V Director is designee to the Children's Cabinet, ECAN and assists Children's Report Card. The Title V Director, CYSHCN Director, CMS FIT program work with key leaders from state agencies, parents, early intervention programs, medical providers/pediatricians, the ICC, regarding unmet EPSDT needs and plans resulting from the Developmental Screening Symposium. The Newborn Hearing Coordinator participates in the D/HH Task Force to address needs of D/HH children. CMS collaborated with Environmental Epidemiology and convened the statewide asthma summit, a series of plans to action oriented meetings with key stakeholders from the public & private sector to create a comprehensive, multidisciplinary approach to pediatric asthma care for NM. Four regional meetings were held. A special follow-up meeting in Hobbs was held fall 08 in response to the high rates of asthma that was discovered. CMS recruited a new pulmonologist from Presbyterian who contracted with the program for 12 pulmonary clinics. Several of these clinics had been cut but were then reinstated. Due to CMS financial support UNM was able to hire a neurologist who is doing more community work.

c. Plan for the Coming Year
July 2009 -- June 2010

Direct: Continue care coordination which is provided by CMS staff and available to all CYSHCN and their families; strengthen linkages to early intervention services and the Part C program, increase child find activities with CYFD and pediatric practices; and provide 127 specialty multidisciplinary specialty clinics statewide.

Population-Based: CMS CYSHCN Program and the CMS FIT Program continue to work with partners in efforts identified to address assurance of EPSDT screening for children and youth in order to increase the identification and early referral to early intervention services for children with or at risk for developmental delays.

Infrastructure Building: The Title V Director will continue as a designee to the Children's Cabinet, and Carol Tyrell is now the Child Health Unit representative to the Early Childhood Action Network. Ms. Peacock will continue to serve in an advisory capacity to the Secretaries of the Departments of Health, Human Services, Aging and Children, Youth and Families in her work with the Children's Cabinet. The program will continue placing children onto NMMIP, the Non-Medicaid, Premium Assistance Program, resulting in widespread coverage for almost all children in New Mexico. The $300,000 appropriation to CMS from the 2007 Legislature CMS is now recurring in the budget.

Performance Measure 06: *The percentage of youth with special health care needs who received the services necessary to make transitions to all aspects of adult life, including adult health care, work, and independence.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	5.9	6	47	47	36
Annual Indicator	5.8	33.7	33.7	33.7	33.7
Numerator					
Denominator					
Data Source					http://mchb.hrsa.gov/cshcn05/SD/newmexico.htm
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

	2009	2010	2011	2012	2013
Annual Performance Objective	36	36	36	36	36

Notes - 2008
Please see notes from 2006 and 2007.

Notes - 2007
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate the NPM06 indicator for the 2005-2006 CSHCN survey. There were also issues around the reliability of the 2001 data because of the sample size. The data for the two surveys are not comparable for PM #06 and the 2005-2006 may be considered baseline data.

Future performance objectives have been lowered to a more attainable level based on the most recent survey results.

Notes - 2006
Source: 2005/2006 National Survey of Children with Special Health Care Needs New Mexico Chartbook Page

http://www.cshcndata.org/Content/StatePrevalence2005.aspx?geo=New%20Mexico

a. Last Year's Accomplishments
July 2007 -- June 2008

Direct: CYSHCN Social Workers continued to provide service coordination and transition planning (involving youth) to youth aged 14-21 through the use of the "CMS Youth Transition Plan."

Enabling: CMS continued the insurance assistance program by paying premiums and deductibles for qualifying clients enrolled in the New Mexico Medical Insurance Pool to give clients a head start on obtaining medical insurance once they transition out of the Program. Intense transition planning is done with clients at least 6 months before transitioning out of the Program to ensure that they are able to pay their insurance premiums. The Healthy Transition New Mexico Coordinating Council has joined forces with the Legislatively-established Statewide Transition Coordinating Council in order to avoid duplicating efforts. This new Council shares information and collaboration on projects affecting youth in transition.

Population Based: CMS contracted with Abrazos Family Health Services to pilot transition training in 2 selected high schools. Due to a lengthy contracting process, Abrazos was unable to meet this objective this year.

Infrastructure Building: The CMS Transition Team utilized evaluation surveys to assess policies used by CYSHCN Social Workers in transition planning with youth. The surveys solicited input from consumers and social workers. Review of surveys indicated that no major changes in policy were necessary at that time.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Transition planning services to youth age 14-21 through care coordination by 45 social workers to cover all 33 counties in New	X			

Mexico.				
2. Educate professionals working with youth in transition & families on all aspects youth transition, through efforts of Statewide Transition Coordinating Council.		X		
3. CMS Regional Transition liaisons review issues, resources, etc. to inform policies regarding transition-age CYSHCN				X
4. CMS funds premiums/deductibles for qualifying YSHCN enrolled in New Mexico Medical Insurance Pool		X		
5. Use NM Behavioral Risk Factor Surveillance System, data for age 18-24 to monitor transition indicators				X
6. Analysis of NM specific data in national survey of CSHCN to identify key issues to improve performance				X
7.				
8.				
9.				
10.				

b. Current Activities
July 2008 -- June 2009

Direct: CYSHCN Social workers provide service coordination and transition planning to youth aged 14-21 through the "CMS Youth Transition Plan."

Enabling: CMS pays premiums and deductibles for qualifying clients enrolled in the NMMIP to give clients a head start on obtaining medical insurance once they transition out of CMS. Intense transition planning is done with clients at least 6 months before.

Population Based: CMS continues membership in the Statewide Transition Coordinating Council (STCC). CMS contracted with Abrazos Family Health Services to provide transition training and serve as advisor to the Program in a pilot project to take place in the Navajo Nation. Budget constraints prevented the Program from taking part in this project, so the contract is being amended. Abrazos will be asked to design curricula for transition training to take place in the future. CMS sponsored a Leadership Institute run by Abrazos. Participants at this conference were educated in several topics, including youth transition.

Infrastructure Building: CMS assessed its policies for CYSHCN Social Workers in transition planning with youth through evaluation surveys soliciting input from consumers and social workers. Clarity on transition planning with CMS clients enrolled in the NMMIP is being added to the section on NMMIP in the CMS Manual of Operating Procedures. CMS applied to HRSA for the Integrated Services Grant with a focus on Medical Home and transition.

c. Plan for the Coming Year
July 2009 -- June 2010

Direct: CYSHCN Social Workers will continue to provide service coordination and transition planning (involving youth) to youth aged 14-21 through the use of the "CMS Youth Transition Plan." Staff training will continue as needs arise.

Enabling: The inspirational transition training video will have Spanish and English sub-titles added so that it can be copied and distributed statewide and nationally along with its accompanying discussion guide. STCC efforts will continue by sharing information, and collaborating on designated projects. CMS will continue to fund premiums and deductibles for qualifying clients enrolled in the New Mexico Medical Insurance Pool to give clients a head start

on obtaining medical insurance once they transition out of the Program.

Population Based: CMS will continue membership in the Statewide Transition Coordinating Council (STCC). CMS will contract with Abrazos to provide transition training tailored to select groups.

Infrastructure Building: CMS will review and update policy as necessary for use by CYSHCN Social Workers in transition planning with youth. Training needs specific to youth transition issues identified will continue throughout FY09. CMS Staff will receive regular updates and resource information on youth in transition through Regional liaisons. If awarded the Integrated Services grant CMS will emphasize transition and medical home. Social workers will be selected to co-locate at primary care practices and work specifically with clients age 16-21. The core MCH performance measures will be integrated into the work around transition.

Performance Measure 07: *Percent of 19 to 35 month olds who have received full schedule of age appropriate immunizations against Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, and Hepatitis B.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	72	73	73	78	82
Annual Indicator	77.9	78.4	76.2	81	76.3
Numerator					
Denominator					
Data Source					http://www.cdc.gov/vaccines/stats-surv/nis/tables/
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	82	82	82	82	82

Notes - 2008
Source: CDC National Immunization Survey data from July 2007-June 2008.
http://www.cdc.gov/vaccines/stats-surv/imz-coverage.htm#nis

CI: 8 %

Notes - 2007

Source: CDC National Immunization Survey data from July 2006-June 2007.
http://www.cdc.gov/vaccines/stats-surv/imz-coverage.htm#nis

CI: 5.4%

Notes - 2006
From CDC National Immunization Survery January-December 2006.

a. Last Year's Accomplishments
July 2007-June 2008

Enabling Services: Continued the Done by One (DBO) campaign, an outreach campaign that encourages providers and parents to get children immunized at the earliest possible opportunity. The New Mexico Done by One optimized childhood immunization schedule has several advantages: children are protected at a younger age; it is easier to give shots to children at a younger age; and it continues education for providers. All the shots are given at 2, 4, 6, and 12 months.

Population Services: At statewide events in During "Got Shots? Protect Tots!" weeks held in 2008 and 2009, participating providers opened their doors on one or more publicized dates and provided immunizations to any child who presented without an appointment, regardless of whether they are a patient or whether they have insurance. Most participating providers also had Presumptive and Medicaid Eligibility services available during the event.

Direct Services: Continued to provide immunization technical assistance to VFC sites through visits by contract nurses. These Immunization Consultants also provide immunization training in provider practices using the Child Health Immunization Learning Initiative (CHILI) presentation. CHILI is four-hour training on immunizations.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Done by One schedule which allows for providers and parent to get children immunized at the earliest possible opportunity.		X	X	
2. “Got Shots? Protect Tots” statewide immunization events.	X		X	
3. Continue the Immunization Consultant technical assistance project	X	X		
4. The VFC program represents an approach to improving vaccine availability nationwide by providing vaccine free of charge to VFC-eligible children through public and private providers.	X		X	X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
July 2008--June 2009

Enabling Services: Continuing participation in the New Mexico Immunization Coalition Steering committee meetings.

Population Services: Ongoing "Got Shots? Protect Tots!" immunization days are being held during two weeks in 2008.

Direct Services: Continuing support for Immunization Consultant technical assistance. Providing CHILI trainings for VFC providers to improve vaccination policy, administration, and vaccine storage and handling among VFC providers. Conducted a randomized school survey of immunization levels in kindergarten and seventh grades.

Infrastructure Services: VFC visits include an evaluation of each practice's immunization "best practices" and immunization coverage levels for a majority of practices. Coverage surveys use the clinical assessment software application (CoCASA). Immunization consultants provide immunization technical assistance and training in vaccine administration, storage and handling, and immunization best practices to New Mexico VFC providers.

c. Plan for the Coming Year
July 2009-June 2010

Enabling Services: Continue participation in the monthly meetings of the New Mexico Immunization coalition Steering Committee. Continue the Done by One Initiative.

Direct Services: [See "Got Shots? Protect Tots," section also see http://hsc.unm.edu/programs/nmimmunization/gotshots.html for more info. Continue Immunization Consultant technical assistance, promote Done by One schedule, and CHILI trainings for VFC providers.

Infrastructure Services: Continue VFC site visits.

Performance Measure 08: *The rate of birth (per 1,000) for teenagers aged 15 through 17 years.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	40	35	35	34.5	33
Annual Indicator	37.9	35.7	34.3	34.3	34.3
Numerator	1703	1619	1592	1592	1592
Denominator	44886	45303	46453	46453	46453
Data Source					New Mexico Vital Records
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	33	33	33	33	33

Notes - 2008
2008 natality data not yet available.

Notes - 2007
2007 Natality data is not yet available.
2007 BBER population estimates are not yet available.

Beginning with the population estimates for 2007, the University of New Mexico Bureau of Business and Economic Research (BBER) updated its estimates of age-specific migration with new data. This change caused a break in continuity between the 2006 and 2007 estimates. Older age groups were affected more than others. For rates calculated from BBER population estimates, any rate differences from 2006 to 2007 must be interpreted with caution, as they may be partly attributable to the change in population estimates used in the rate denominators.

Notes - 2006
Denominator: Number of females aged 15-17 an estimate derived from national census data by the Bureau of Business and Economic Reasearch (BBER) at the Universtiy of New Mexico.

Numerator: From the DOH Vital Statistics Natality Summary
http://www.health.state.nm.us/pdf/2006%20Vital%20Statistics%20Natality%20Summary.pdf

a. Last Year's Accomplishments
July 2007 -- June 2008

Direct: The total number of adolescents aged 15-17 seen at clinics for comprehensive reproductive health services was 6768; 6184 females and 584 males.

Enabling: Local health offices (LHOs) provided education and outreach for 5,092 clients aged 15-17 at schools, detention centers, and community centers on reproductive health topics such as abstinence, decision making skills, healthy relationships, male responsibility, parent-child communication, safer sex, sexual responsibility, teen pregnancy issues and sexually-transmitted infections. The NM Department of Health Family Planning Program (FPP) provided technical assistance and oversight for the South Valley Male Involvement Project (SVMIP) in Albuquerque to promote male involvement in reproductive health by providing educational services to increase young men's knowledge and skills in addressing their reproductive health needs and providing outreach to promote male clinical services. SVMIP staff reached 1,097 individuals ages 15-17 with education and outreach.

Population-Based: Through the Adolescent Pregnancy Prevention Program (APPP), the FPP funded and supported evidence-based community education programming. A Request for Proposals (RFP) for educational programming for teen pregnancy prevention was issued in March 2007. Five community-based projects were funded to serve teens in Bernalillo, San Miguel, Taos, Torrance and Valencia Counties. Funding was also provided for program evaluation of these projects and statewide technical assistance and training. Funding was for implementation of an evidence-based comprehensive sex education or service learning project, using an age appropriate curriculum, including peer education or at least one youth development strategy.

The recommended youth development strategies were ones that were listed in Linking Pregnancy Prevention to Youth Development from Advocates for Youth. These strategies that have a positive effect on teen pregnancy prevention are:
- Involve families
- Strengthen academic skills and opportunities
- Provide intensive services for foster care, homeless, migrant, and out-of school youth
- Strengthen school-to-work programs

- Offer mentoring programs
- Involve young people in their communities
- Involve the community in expanding life options for youth
- Strengthen economic opportunities for both men and women
- Offer prevention services and support to men
- Provide youth development activities that enhance self-esteem
- Ensure access to mental health counseling

The New Mexico State Legislature authorized an additional $525,000 in funding for teen pregnancy prevention education programming beginning in July, 2008. As a result, there were four new sites for the Teen Outreach Program in Bernalillo County and one in Cibola County. There was also an intensive case management program for teen pregnancy prevention in Doña Ana County. The focus of the programming was to complement SBHCs that provide comprehensive services in counties with high teen birth rates. The SBHCs are part of Elv8, a network of educational, health and family services for middle school students that provides: extended-day learning, comprehensive school-based healthcare, and family supports in Bernalillo, Cibola and Doña Ana Counties.

The NM FPP collaborated with the New Mexico Teen Pregnancy Coalition (NMTPC), the Annie E. Casey Foundation and NM Health Promotion-Region 3 to support the South Valley/Plain Talk program in Albuquerque. The FPP also collaborated with the NMTPC, Dona Ana County-HHS, Nirvana Mañana Foundation, Con Alma Health Foundation, New Mexico Community Foundation and Paso del Norte Foundation to support a Plain Talk site in Doña Ana County. Plain Talk is a neighborhood-based initiative to help adults, parents and community leaders to communicate effectively with young people about reducing adolescent sexual risk-taking.

Infrastructure Building: Challenge 2010, a project of the FPP and the NMTPC, asks counties to reduce teen births by 15% from 2006-2010. In 2008, the third year of Challenge 2010, 4 counties reduced birth rates to 15-17 year olds by at least 9%. Challenge 2010 provides data on both 15-17 year olds and 15-19 year olds to focus attention on birth rates for both groups in each county. The 2008 Challenge pamphlet focused on tips for adult teen communication strategies that positively affect teen pregnancy prevention.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Comprehensive reproductive health services will be provided to clients aged 15-17 at local health offices and clinical contractor sites.	X			
2. Public health offices will provide education and outreach for clients aged 15-17 on reproductive health topics such as healthy relationships, male responsibility, safer sex, sexual responsibility, teen pregnancy and sexually-transmitted infections.		X		
3. The FPP will provide oversight for the South Valley Male Involvement Project to support educational services to increase young men's knowledge and skills in addressing their reproductive health needs and outreach to promote male clinical services.		X		
4. Through the Adolescent Pregnancy Prevention Program, the FPP will fund and support evidence-based community education programming.			X	
5. The FPP will support "Plain Talk" a neighborhood-based initiative to help adults, parents and community leaders to communicate effectively with young people about reducing			X	

adolescent sexual risk-taking				
6. The Adolescent Pregnancy Prevention Program will evaluate evidence-based community education programming.				X
7. The FPP and the NMTPC will present data for the Challenge 2010.				X
8. The South Valley Male Involvement Project will continue training interns to provide peer education and coordinate community outreach activities.				X
9.				
10.				

b. Current Activities
July 2008 -- June 2009

Direct: Comprehensive reproductive health services are provided to clients aged 15-17 at Local Health Offices (LHOs) and clinical contractor sites.

Enabling: LHOs continue providing education and outreach for clients aged 15-17. The FPP will continue to provide technical assistance and oversight for the South Valley Male Involvement Project.

Population-Based: The main focus of the APPP is an evidence based program, the Teen Outreach Program (TOP). TOP, a service learning program designed to prevent teen pregnancy and academic failure promotes positive youth development with community-based volunteer service and curriculum-based activities. The NM DOH FPP supports 17 TOP sites in 10 counties: Bernalillo (4 sites), Dona Ana (3 sites), Chaves, Cibola (2 sites), Luna, Rio Arriba, San Miguel, Sierra, Torrance and Valencia (2 sites). There are also two comprehensive sex education sites with youth development strategies including service learning and peer education.

The FPP continues to partner with NMTPC and private foundations for delivery of the Plain Talk Program to increase adult-teen communication in the South Valley in Albuquerque and in Doña Ana County.

Infrastructure Building: The APPP evaluates the evidence-based community education programming. The FPP and the NMTPC will announce the 2009 results of the Challenge 2010 at a teen pregnancy prevention conference in May.

c. Plan for the Coming Year
July 2009 -- June 2010

Direct: Comprehensive reproductive health services will be provided to clients aged 15-17 at LHOs and clinical contractor sites. Clinical services include providing a contraceptive method and/or a clinical exam visit. The clinical exam visit includes: a medical history/physical, laboratory tests (including pap smear), testing and counseling for sexually transmitted diseases, family planning counseling, pregnancy testing (if needed), a supply of a contraceptive method of choice.

Enabling: LHOs will provide education and outreach for clients aged 15-17.
The FPP will provide technical assistance and oversight for the South Valley Male Involvement Project.

Population-Based: The NM DOH, the FPP and the New Mexico Teen Pregnancy Coalition will continue to recommend four population-based strategies to prevent teen pregnancy. Comprehensive sex education teaching that abstinence is the best method for avoiding STDs and unintended pregnancy, but also teaching about condoms and contraception. Teaching

interpersonal and communication skills and helping young people explore their own values, goals, and options, to make responsible decisions about their sexuality and reproductive health.
Male involvement programs for prevention efforts that specifically target boys and young men. Effective programs for boys include programs with community service or other out-of-school activities with a cultural component.
Adult-teen communication programs to give adults information and skills to communicate effectively with young people about reducing risky sexual behavior. Parents influence teen decisions about sex more than their friends, the media, or their siblings. Open, honest conversation makes it easier for teens to postpone sexual activity and avoid teen pregnancy.
Service learning programs that include community based volunteer service and curriculum-based discussions and activities, designed to promote healthy behavior for successful achievement in school and attainment of life-long goals.

The main focus of programming will continue to be the Teen Outreach Program (TOP). TOP, a service learning program designed to prevent teen pregnancy and academic failure promotes positive youth development with community-based volunteer service and curriculum-based activities. The FPP will also support the TOP as part of the Elev8 project.

Performance Measure 09: *Percent of third grade children who have received protective sealants on at least one permanent molar tooth.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	44	48	48	50	50
Annual Indicator	48	48	48	48	48
Numerator					
Denominator					
Data Source					NM Office of Oral Health
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	50	50	50	50	50

Notes - 2008
This is a rough estimate; no surveillance was done in this year. The dental program reported the same level of effort, hence the same estimated level of coverage. This coverage is among children enrolled in schools with a high proportion of children on the free or subsidized meal program

The 2007 National Survey of Children's Health found that 91.6 % of children aged 6-11 had no unmet need for oral health care. 89.2% in that age group had one or more preventive care visits during the past 12 months.

Notes - 2007
This is a rough estimate; no surveillance was done in this year. The dental program reported the same level of effort, hence the same estimated level of coverage. This coverage is among children enrolled in schools with a high proportion of children on the free or subsidized meal

program

The 2007 National Survey of Children's Health found that 91.6 % of children aged 6-11 had no unmet need for oral health care. 89.2% in that age group had one or more preventive care visits during the past 12 months.

Notes - 2006
This is a rough estimate; no surveillance was done in this year. The dental program reported the same level of effort, hence the same estimated level of coverage. This coverage is among children enrolled in schools with a high proportion of children on the free or subsidized meal program

The National Survey of Children's Health found that 78.8% of 6-9 year olds had insurance that pays for routine dental care. 79.0% of 6-9 year olds received all the routine preventive dental care they needed in the past 12 mos. This would mean that roughly 67,150 children age 6-9 goat a sealant. 66% had dental insurance and received all the routine preventive dental care they needed in past 12 mos. 12% did not have dental insurance and received all the routine preventive dental care they needed in past 12 mos. 1% didn't know if their child had dental insurance & received all the routine preventive dental care they needed.

a. Last Year's Accomplishments
Last year's accomplishments July 2007 -- June 2008

Direct:

The State Office of Oral Health (OOH) conducts a school based dental sealant program. OOH also funds contractors to provide basic dental services to the indigent.

1,180 3rd grade children received at least a dental sealant in addition to dental sealant retention checks through state school based program. OOH contractors provided 4,329 children with a dental sealant.

The State school based program consists of the following: the child receives oral health education training, a screening and dental sealant application if the molar is healthy. The parents/guardians of the child receive a letter from the program identifying whether or not a child received a dental sealant. If the child needs additional dental treatment a list of providers is forwarded to the parent. In Santa Fe County, a number of 3rd graders participated in a dental case management pilot project.

Enabling:
Population-Based:
Infrastructure Building:

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Application of dental sealants for 3rd grade children.	X			
2. DOH Strategic Plan, Program Area #2 Task #8	X			
3. Office of Oral Health provides direct services and contracts with providers to ensure the delivery of services.	X	X		
4. Dental case manager pilot project implemented and a number of 3rd graders participated in the project.			X	
5. Increased partnership with non-state program offering same				X

services to target 3rd grade children and data collection.				
6. NM Legislature has expanded the duties for dental hygienists to apply fluoride varnish and in some case dental sealants		X		
7.				
8.				
9.				
10.				

b. Current Activities
Current activities July 2008 -- June 2009

Direct:

The State OOH is conducting a school based dental sealant program. OOH also funds contractors to provide basic dental services to indigent children.

For the first six months of the fiscal year 727 3rd grade children have received a dental sealant(s) in addition to dental sealant retention checks through state school based program. 3,331 children received at least a dental sealant through state school based program.

The State school based program consists of the following: the child receives oral health education training, a screening and dental sealant application. In Santa Fe County some of the children received dental case management services. The parents/guardians of the child receive a letter from the program identifying whether or not a child received a dental sealant. If the child needs additional dental treatment a list of providers is forwarded to the parent.

OOH is conducting a surveillance project to determine the oral health status of NM 3rd grade elementary school aged children.

c. Plan for the Coming Year
Plan for coming year July 2009 -- June 2010

Direct:

In SFY 10 OOH will be continuing the school based dental sealant program provide contractors with funds for dental sealant activities. Despite the economic crisis affecting state governments the program will maintain funding to continue the program at the current level.

Performance Measure 10: *The rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	5.5	5.5	6.9	6.9	7.5
Annual Indicator	7.3	6.6	8.0	6.4	6.4
Numerator	30	27	33	26	26
Denominator	411488	409523	411065	405808	405808
Data Source					NMVRHS analysis by

					MCH Epi
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	6	6	5	5	5

Notes - 2008
2008 Mortality data is not yet available.

Please note that the annual performance objective for 2008 should be "6"

Notes - 2007
Source:

Numerator: NMVRHS
Denominator: BBER

Beginning with the population estimates for 2007, the University of New Mexico Bureau of Business and Economic Research (BBER) updated its estimates of age-specific migration with new data. This change caused a break in continuity between the 2006 and 2007 estimates. Older age groups were affected more than others. For rates calculated from BBER population estimates, any rate differences from 2006 to 2007 must be interpreted with caution, as they may be partly attributable to the change in population estimates used in the rate denominators.

Notes - 2006
Numerator: NMVRHS
Denominator: BBER

a. Last Year's Accomplishments
July 2007 - June 2008

Enabling Services: The SAFE KIDS network did not expand to more than 11 communities due to lack of funds and sponsors willing to provide both funds and administration. Negotiations for the transfer of the Curry County SAFE KIDS Coalition sponsorship from the City of Clovis Fire Dept. to the hospital in nearby Portales were initiated, but not completed. Carlsbad Regional Medical Center in Eddy County and Nor-Lea Hospital in Lea County have now both become new official chapters and are providing seasonal safety events, as well as participating in health fairs.

Population Services: The New Mexico SAFE KIDS Coalition (NMSKC) purchased $30,000 worth of helmets and distributed them statewide in collaboration with the Helmets For Kids Coalition, the Brain Injury Advisory Committee, and the Brain Injury Association. The NMSKC network will continue to collaborate with Safer New Mexico Now (SNMN) on the training of child car seat technicians and production of child car seat clinics. SAFE KIDS representatives also continue to teach home safety workshops at the 16 annual Regional Early Care Education Conferences (RECEC) throughout New Mexico.

Infrastructure Services: The Child Helmet Safety Act became a law on July l, 2007, and the strategy for implementation began with a press conference at the New Mexico Capitol Bldg., featuring Lt. Gov. Diane Denish, and the legislative sponsor, Senator Linda Lopez. Nonprofits

and public agencies collaborated throughout the year to distribute and fit children with helmets statewide.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Expand network of SAFE KIDS chapters with support from statewide coalition and collaboration with nonprofits				X
2. Strengthen relationship with Safer New Mexico Now. SNMN will advocate for informed policy-making, provide education, support law enforcement, offer resources, and nurture public understanding			X	
3. Continue to support the Regional Early Care Education Conference (RECEC) collaborates to strengthen the ties between State and community agencies dealing with the health and safety of the child care environment		X		
4. Pursue additional funding mechanisms to finance SAFE KIDS programs statewide				X
5. Continue to provide contracts to SAFE KIDS Coalition and Chapters statewide for programs		X		
6.				
7.				
8.				
9.				
10.				

b. Current Activities
July 2008 - June 2009

Enabling: The NMSKC is purchasing ~$30,000 worth of helmets and distributing them to the SAFE KIDS network as part of the implementation campaign for the new helmet law. The NMSKC is increasing its collaboration with NMDOT, PED, CYFD and many nonprofits to implement the Child Helmet Safety Act statewide in every community.

Population: Partnership with the nonprofit Brain Injury Association to administer the NMSKC is being considered. A "Safe Skate Park Campaign" and a "Safe Sleep Campaign" are being initiated this year. The SAFE KIDS network is being expanded from 12 to 16 locations. Grant, Dona Ana, Chaves, Sandoval, Rio Arriba and Taos Counties are planning SAFE KIDS chapters.

Infrastructure: A statewide New Mexico SAFE KIDS Coalition budget, funded by the Children's Cabinet, will not be introduced at the 2009 Legislature because of lack of funding. The intent was to provide a permanent state allocation of $100,000 - $300,000 to purchase and distribute child car seats, non-motorized vehicle helmets, and smoke alarms for events produced by SAFE KIDS coalitions. A portion of the funding was to be used to train home inspectors for the new First Born program, which provides 6-12 home visits per year for two years to new parents. A $150,000 grant proposal to the New Mexico Automobile Dealers Association was also rejected due to the collapse of the automobile sales market, and the subsequent lack of grant funds available.

c. Plan for the Coming Year
2009 -- June 2010

Enabling Services: Helmet use compliance remains very low among older teens, as we expected, but this year we are trying to make one of our weakest links, skate park helmet compliance, into our demonstration classrooms of safety, enlisting the teens themselves to be safety mentors to the younger children. So far we have been very encouraged by the response to our request to have more teens involved as safety advocates, and the "Safe Skate Park Campaign" will be operational statewide in the coming year. Soon we will also be joining the Cribs for Kids Campaign of the Children's Hospital of Philadelphia to make our "Safe Sleep Campaign" fully operational as well. Cribs for Kids apparently is already in 42 states, advocating for charities, nonprofits, hospitals and insurance companies to purchase and distribute portable cribs, just as we distribute car seats, to new parents. Graco manufacturers a crib that is only available via Cribs for Kids at the price of $50 that has been used by thousands of children without incident since 2002. Most of the suffocation incidents involve co-sleeping with adults, and the portable cribs allow some parents to have the baby in the room with them, but not in the adult bed, if the regular crib does not fit. It also may allow for the crib to be placed on the adult bed so that the baby is safe and not vulnerable to the possibility of suffocation.

Population Services: We are soliciting donations and volunteers to start new SAFE KIDS chapters in Silver City, Las Cruces, Roswell, Gallup, Espanola and Taos this summer and fall, and doing this in conjunction with the skate park campaign. Meetings will take place in Silver City, Las Cruces and Roswell in May, and most likely the other organizational meetings will take place in July and August. Obviously we want as much Native American participation as possible in Gallup, Espanola and Taos, given the representation in the community. New Mexico continues to offer 16 mini-conferences per year to home daycare providers so that they can comply with the requirement of 6 hrs. of education per year for certification, and we continue to offer home safety training at about 8-10 conferences per year.

Infrastructure Services: If there is sufficient funding, this home safety program will be expanded from home day care providers to teen, foster, adoptive, grand and new parents, of which there are approximately 100,000 currently residing in New Mexico. New Mexico has initiated home visitation programs for new parents in seven counties, with plans to go statewide over the next decade. In conjunction with this program, we are revising our current home safety program for home daycare providers, which we began in 2003, to cater to the one on one visits of home visitation specialists with families, targeting the safety of newborns particularly.

Performance Measure 11: *The percent of mothers who breastfeed their infants at 6 months of age.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective			70	50	43
Annual Indicator		68	44.3	41.8	41.8
Numerator					
Denominator					
Data Source					http://www.cdc.gov/BREASTFEEDING/DATA/NIS_data/ind
Check this box if you					

cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	45	45	45	45	45

Notes - 2008
41.8% is the percent of infants that were fed any breast milk to six months or beyond. This is the result from the 2007 National Immunization Survey of children born in 2005.

CI: 8.4%

The percent of infants from that same cohort that were exclusively breastfed was 37.2% at three months, and 15% at six months.

Healthy People 2010 goals for exclusive breastfeeding are 40% at three months and 17% at six months.

Source: http://www.cdc.gov/breastfeeding/data/NIS_data/data_2004.htm

Notes - 2007
41.8% is the percent of mothers that breastfed their infants any breast milk to six months or beyond. This is the result from the 2007 National Immunization Survey of children born in 2005. The number is provisional and the final number will be available in August, 2009.

The provisional percent of mothers that exclusively breastfed their infants, according to this same survey, was 37.2% at three months, and 15.0% at six months. Healthy People 2010 goals for exclusive breastfeeding are 40% at three months and 17% at six months.

Source: http://www.cdc.gov/breastfeeding/data/NIS_data/data_2004.htm

Notes - 2006

1. Annual indicator is from 2005 National Immunization Survey (NIS) breastfeeding rate for New Mexico.

2. The annual performance objective of 70 is from the previous version of the NPM that measured breastfeeding initiation. The objective has been changed to 50; that is the Healthy People 2010 goal for breastfeeding duration at six months.

3. Breastfeeding duration rates at six months in New Mexico for previous years were 2003: 39.0 and 2004: 42.2. According to the NIS.

New note for 2006: 44.3% is the percent of mothers that breastfed their infants any breast milk to six months or beyond. This is the result from the 2006 National Immunization Survey of children born in 2004.

Exclusive breastfeeding rates for this same birth cohort were 37.5% at three months and and 17.9% at six months.

http://www.cdc.gov/breastfeeding/data/NIS_data/index.htm

a. Last Year's Accomplishments

Direct: UNM and Presbyterian Hospitals in Albuquerque, with support from the NM Breastfeeding Task Force (BFTF) established free Lactation Clinics that provide postpartum breastfeeding consultations and breastfeeding classes monthly; they also banned the dissemination of formula gift packs to mothers upon hospital discharge. WIC provided group breastfeeding support sessions and individual counseling to pregnant and breastfeeding mothers; a choice between 4 different types of breast pumps for breastfeeding mothers; and other breastfeeding aides and devices as needed by high-risk breastfeeding mothers.

Enabling: WIC continued operation of the WIC Peer Counselor Program; expanded peer counseling program to 31 sites, and number of peer counselors to 40.

Population-Based: The NM BFTF and WIC worked to increase public acceptance of breastfeeding through the development and dissemination of 6,000 "Positive Images of Breastfeeding" 2008 Calendars to families and healthcare providers statewide; created public awareness of breastfeeding through WIC Clinic and BFTF celebrations for World Breastfeeding Week, August 1-7, 2008. WIC continued the TV media campaigns, and produced 6 segments about the new worksite breastfeeding law which were aired on the local NBC affiliate's Good Day New Mexico Show.

Infrastructure Building: WIC continued work on computer system to improve data collection for tracking client breastfeeding duration; provided breastfeeding training for health care professionals through: 7 WIC new employee "Breastfeeding Basics" workshops; the NM BFTF Annual Advanced Concepts in Breastfeeding Conference; Mother Journey's Lactation Educator Course; an IBLCE Exam Prep Course; and 3 Loving Support Peer Counselor Trainings. WIC and the NM BFTF continued the project "Using Loving Support to Build a Breastfeeding Friendly Community" in Grants which included presenting health care professional training and assessment of community needs. The NM BFTF awarded 3 mini-grants for breastfeeding duration projects to 3 local BFTF coalitions. Valencia County WIC/BFTF and Eddy County WIC/BFTF continued providing breastfeeding resources to local health care providers through the WIC funded Physician Outreach Project. Access for healthcare professionals to adequate breastfeeding research, supplies and resources continued through development of WIC's intranet and internet websites, and the BFTF website.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. WIC Breastfeeding Education and Counseling	X			
2. WIC Breastfeeding Peer Counseling		X		
3. WIC and BFTF Website Education and Activities				X
4. Annual Breastfeeding Continuing Education/Trainings for healthcare professionals				X
5. BFTF and WIC World Breastfeeding Week Celebration			X	
6. WIC Breastfeeding Media Campaign			X	
7. "Using Loving Support to Build a Breastfeeding Friendly Community" Model				X
8. BFTF Mini-Grants for Breastfeeding Projects Statewide.				X
9. UNM and Presbyterian Hospitals' Lactation Clinics	X			
10. NN Legislation in Support of Breastfeeding			X	

b. Current Activities

Detailed information about NM WIC's Breastfeeding program is available on WIC's website: www.health.state.nm.us/phd/wicsite/breastfeeding.php

Direct: 3 NM hospitals have offered free Lactation Clinics and banned formula discharge gift bags to new mothers. WIC provided prenatal backpacks filled with support materials, along with education and breastpumps for mothers.

Enabling: WIC continued operation of the WIC Peer Counselor Program; expanded to 35 sites and 43 peer counselors.

Population-Based: BFTF and WIC issued 6,000 "Positive Images of Breastfeeding" 2009 NM Calendars statewide. WIC and BFTF participated in World Breastfeeding Week. WIC continued the TV fathers' involvement media campaign. The 2009 NM Legislative Session passed a House Memorial to appoint a task force to assess breastfeeding support NM student-mothers receive.

Infrastructure Building: WIC continued work on breastfeeding data collection; provided breastfeeding education for staff through 4 Breastfeeding Basics trainings, the NM BFTF Annual Advanced Concepts in Breastfeeding Conference, and 4 Peer Counselor Trainings. The "Using Loving Support to Build a Breastfeeding Friendly Community" project in Grants established a mothers' support group. The NM BFTF awarded mini-grants for breastfeeding duration projects to 2 local BFTF coalitions. Access to adequate breastfeeding research and resources continued through development of WIC's intranet and internet websites, and the BFTF website.

c. Plan for the Coming Year

Indicator Data: Track baseline breastfeeding duration at infant's 6th month by June 2010. WIC will increase percentage of infants that are still breastfed at six months by three percentage points each year 2009 through 2011.

Direct: Increase number of hospitals in New Mexico that operate postpartum Lactation Clinics and that ban formula discharge bags; WIC will continue to provide a prenatal backpack filled with a book, DVDs, father and grandparent pamphlets and other breastfeeding support materials to all pregnant mothers; group breastfeeding support sessions and individual counseling to pregnant and breastfeeding mothers; a choice between 4 different types of breast pumps for breastfeeding mothers; and other breastfeeding aides and devices as needed by high-risk breastfeeding mothers.

Enabling: WIC will continue to expand its Peer Counselor Program to reach half of all WIC clients

statewide by 2011.

Population-Based: BFTF and WIC will continue the development and dissemination of "Positive Images of Breastfeeding" Calendars annually through WIC and other health care providers statewide. Public awareness of breastfeeding through WIC Clinic and BFTF celebrations for World Breastfeeding Week will take place August 1-7 annually. WIC will continue the TV media campaigns through development of 3 new TV commercials educating the public and the new breastfeeding/workplace law. The NM BFTF will lobby the NM legislature to amend the workplace law to include schools. Additional WIC clinics/BFTFs will implement the Physicians' Outreach Project as funding allows.

Infrastructure Building: WIC will begin tracking and continue analyzing client breastfeeding duration data through Breastfeeding Duration Reports. PRAMS breastfeeding data will continue to be analyzed. Breastfeeding education and training opportunities for health care professionals will continue to be provided through: WIC "Breastfeeding Basics" training, the NM BFTF Annual Advanced Concepts in Breastfeeding Conference, a Lactation Educator Specialist Course and the Loving Support Peer Counselor Trainings. Access for healthcare professionals to adequate breastfeeding research, supplies and resources will continue through on-going updates to the WIC staff's intranet site and the BFTF website. WIC will post its new internet site to include breastfeeding education, as well as WIC clinic breastfeeding resources and support for the public to access. Development of local community breastfeeding projects to increase the duration of breastfeeding will continue through NM BFTF mini-grant funding. The number of IBCLCs in New Mexico will continue to be increased through providing NM BFTF scholarships for IBCLC exam expenses, and providing WIC staff with study resources. WIC and the NM BFTF will expand implementation of "Using Loving Support to Build a Breastfeeding Friendly Community" Project to the community of Clovis, NM.

Performance Measure 12: *Percentage of newborns who have been screened for hearing before hospital discharge.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	95	95.5	95.7	96	96
Annual Indicator	92.0	92.3	92.3	92.3	92.3
Numerator	25567	26616	27625	27625	27625
Denominator	27797	28822	29918	29918	29918
Data Source					Children's Medical Services Program
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	96	96	96	96	96

Notes - 2008
This is a rough estimate. An accurate count is not available at this time. Efforts are under way to have more more accurate hearing screening data within the next two years.

Notes - 2007
Please see note from 2006.

Notes - 2006
This is a rough estimate. An accurate count is not available at this time. We are not able to obtain an accurate count at this time. Efforts are under way to have more more accurate hearing screening data within the next two years.

a. Last Year's Accomplishments
July 2007 -- June 2008

Enabling Services: Continued to follow Joint Commission on Infant Hearing (JCIH) standard of care, screening within one month of birth, identification of hearing loss by three months and referral to early intervention services by 6 months of age. Children's Medical Services (CMS) social workers provided care coordination, linkage to medical home, and family support services to maintain the infrastructure of the program.

Population Based: The Coordinator met with the state school for the deaf (NMSD) and the CDHH to address lack of access to audiology services.

Infrastructure: Maintained the number of birthing hospitals that provide universal screening at 100%. The program provided home-birth midwives with referral forms with protocol to ensure that infants born at home have access to hearing screens and made arrangements with local audiologists to provide initial screening. In Taos, the local hospital agreed to screen babies born at home or at the midwifery center in that community. The coordinator participated in and chaired CDC sponsored Early Hearing Detection and Intervention (EHDI). Minority Committee: This committee addresses access issues for minorities. Family materials including informational brochures, letters and a family handbook were revised in English and Spanish. The Coordinator continued to monitor compliance with the Public Health reporting requirements whereby medical providers are mandated to report to DOH suspected and/or confirmed hearing loss in children from birth to 4 years. The Newborn Hearing Screening Advisory council met regularly (every two to three months) to advise the program on procedures and identify areas for improvement.

The Coordinator worked in collaboration with the Public Health Division Medical Director along with other programs within the bureau- the birth defects and surveillance program, the genetic screening program and the pre-natal home visiting program to implement a case management and data tracking system. A system was chosen, Challenger Soft. The prenatal program became operational and NBHS NBGS and birth defect surveillance begin mapping.

The Coordinator worked with the Advisory council to continue to assist with implementation of the 2006 legislation requiring insurance coverage for hearing aids and Medicaid rate increases, Private insurers now mandated to provide coverage for hearing aids for children. Medicaid reimbursement increased from $400 to $1400 per aid. CMS awarded $100,000 to cover costs of D/HH children who are non-Medicaid eligible. This money became reoccurring in the CMS budget. The Coordinator worked closely with the Commission for the Deaf (CDHH) and the New Mexico School for the Deaf (NMSD) on best utilization of funds which included increasing access to hearing screen for children birth to three. Screeners are being purchased for all early intervention programs in the state. These programs serve as the safety net in many communities.

NBHS was awarded three years of HRSA funding and has submitted an application to the CDC for funding to enhance the database that is being created.

The Coordinator is working with UNM telehealth program, Utah State, the Navajo Nation and Rehoboth McKinley Hospital in Gallup to initiate a audiology telehealth project in the Gallup region. Training provided to midwives and hospitals as needed this year in collaboration with the Metabolic Screening program. The Coordinator is an active participant on the Deaf and Hard of Hearing Task force and was asked to be on the Board of Directors for Hands and Voices.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Training of all hospital staff on proper procedure and protocol in collaboration with the Newborn Genetic Screening program and Vital records				X
2. Monitor compliance with reporting requirements				X
3. Enhance data collection system within Family Health Bureau				X
4. Expand data linkage to Part C program			X	
5. Facilitate advisory council meetings				X
6. Facilitate EHDI Diversity Committee				X
7. Implement audiology telehealth project				X
8.				
9.				
10.				

b. Current Activities
July 2008 -- June 2009

Enabling: The program hired a short term follow-up coordinator, centralizing the process based on the successful model used by the genetic screening program. CMS social workers continue to provide long term care coordination, linkage to medical home, family support services.

Population-Based: Coordinator meets regularly with NMSD and the CDHH to address lack of access to audiology services and now DOH Secretary. New case management, tracking and surveillance database was implemented.

Infrastructure Building: NBHS was awarded three years of HRSA funding and three years of CDC funding which has resulted in program restructuring. Advisory Council meets to improve follow-up activities, maintain consistent policies. Coordinator continues as chair of CDC/ EHDI Diversity Committee, to address access issues for minorities. Case management mapping and data collection system development was implemented for Jan 2009. CMS monies for non-Medicaid D/HH children are being used to purchase screening equipment for Early Intervention providers. The Coordinator is working with UNM telehealth program, Utah State, the Navajo Nation and Rehoboth McKinley Hospital in Gallup to initiate a audiology telehealth project in the Gallup region. Training provided to midwives and hospitals as needed this year in collaboration with the Metabolic Screening program. CMS continues involvement with D/HH task force and Hands and Voices.

c. Plan for the Coming Year
July 2009 -- June 2010

Enabling: The program will continue to work with the short term follow-up coordinator to improve follow-up by reducing time between first contact and discharge from hospitals and centralizing

procedures. CMS social workers will continue to provide long term care coordination, linkage to medical home, family support services.

Population-Based: Coordinator will continue to meet with NMSD and the CDHH to address lack of access to audiology services. Enhance new case management, tracking and surveillance database.

Infrastructure Building: Maintain the number of birthing hospitals that provide universal screening at 100%. . Continue to provide training and technical assistance to hospital providers, midwives and CMS staff in collaboration with Vital Records and the Metabolic Screening program to improve loss to follow-up. Enhance the use of a statewide data collection system to track referral and follow-up information in partnership with Vital Records, Birth Defects, Metabolic Screening program. Begin linkage with Part C. Continue the Newborn Hearing Screening Advisory Council with a focus on improving follow-up activities, revising policy on follow-up for infants with risk factors and maintaining consistent policies for screening. Coordinator will continue to participate and chair CDC sponsored EHDI Minority Committee, which is addressing access issues for minorities. Maintain distribution of family materials including informational brochures and family handbooks in English and Spanish. Monitor compliance with the Public Health reporting requirements established whereby medical providers are mandated to report to DOH suspected and/or confirmed hearing loss in children birth to 4 years. Implement Telehealth audiology pilot project in the Northwest. The coordinator will continue to participate in the D/HH Task Force

Performance Measure 13: *Percent of children without health insurance.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	18	10	10	10	10
Annual Indicator	9.6	9.8	9.8	11.9	11.9
Numerator		52160	52250	58681	58681
Denominator		532241	535705	493459	493459
Data Source					National Survey of Children's Health
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	10	10	10	10	10

Notes - 2008
Source:
National Survey of Children's Health
http://nschdata.org/Content/#

NM has reset its target to 10 for period 2004 through 2010; it is not reasonable to set it lower - the state should be able to maintain ground if present priorities remain actively pursued.

Notes - 2007
Source:
National Survey of Children's Health
http://nschdata.org/Content/#

NM has reset its target to 10 for period 2004 through 2010; it is not reasonable to set it lower - the state should be able to maintain ground if present priorities remain actively pursued.

Notes - 2006
Please see note for 2005.

a. Last Year's Accomplishments
July 2007 -- June 2008

Direct: The Families FIRST program, and the Children's Medical Services (CMS) program continued to provide assessment of the insurance options for clients, and complete Presumptive Eligibility/Medicaid On-Site Application and Assistance (PE/MOSAA) if the client is eligible. Department of Health (DOH) worked collaboratively with community based programs, and school based health centers, reaching out to children and families to increase the number of children who are insured.

Enabling: Title V Maternal Child Health (MCH) and state general funds were used to cover services for pregnant women (Hi Risk Prenatal Fund) and children (Healthier Kids Fund) who have no other source of coverage.

Population-Based
Infrastructure Building: The Medicaid 1115 waiver continued to provide family planning services. Gaps in services were monitored and identified thru the Early & Periodic Screening, Diagnosis, & Treatment (EPSDT)-Advisory Committee. DOH worked collaboratively with the Children's Cabinet to address universal coverage for children

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Participate in the EPSDT-Medicaid Advisory Committee	X			
2. FHB will work with partners to identify statewide strategies to address issues of uninsured or underinsured.	X			
3. Families FIRST and CMS programs will provide assessment of insurance options for clients, and complete PE/MOSAA applications for children or youth who are eligible.	X			
4. Working collaboratively to the birth certificate requirement.	X			
5. Title V MCH and State General funds are being used to cover services to pregnant women and children who have no other source of coverage.		X		
6. Continue to reach out to families to increase the number of children who enroll for Medicaid and provide information to families about the new program which will provide assistance to pay for health insurance.				X
7.				
8.				
9.				
10.				

b. Current Activities
July 2008 -- June 2009

Direct: Family Health Bureau (FHB) staff participates in the EPSDT-Medicaid Advisory Committee. FHB works with partners to identify statewide strategies to address issues of uninsured or underinsured. Families FIRST and CMS programs complete PE/MOSAA applications for eligible children or youth. Medicaid continues to have a twelve-month renewal process. DOH is working collaboratively with HSD to identify community events that would provide opportunities for outreach and Medicaid enrollment of eligible children.

Enabling: Title V MCH and State General funds are being used to cover services to pregnant women (Hi Risk Prenatal Fund) and children (Healthier Kids Fund) who have no other source of health care coverage.

Infrastructure Building: About 21,000 children, 5 yrs old and under are uninsured in New Mexico. The Children's Cabinet is working with the Governor and State Legislature to address universal coverage for children. Information is being shared with families about the availability of funds to assist families with the cost of health insurance premiums. HSD's increased the amount of income that can be disregarded and the amounts that can be deducted from gross income, thereby increasing the number of families who qualify for Medicaid.

c. Plan for the Coming Year
July 2009 -- June 2010
Direct: DOH will continue to reach out to children and families to increase the number of children who are insured. This includes the efforts of Families FIRST and CMS staff who are actively involved in assisting families to complete the PE/MOSSA application.

Enabling: Title V MCH and state general funds will continue to be used to cover services for pregnant women (Hi Risk Prenatal Fund) and children (Healthier Kids Fund) who have no other source of coverage.

Infrastructure Building: DOH will work collaboratively with HSD to increase the number of eligible children enrolled in Medicaid. The Children's Cabinet continues to work with the Governor and the State Legislature to implement universal health care coverage for all New Mexicans, including children.

Performance Measure 14: *Percentage of children, ages 2 to 5 years, receiving WIC services with a Body Mass Index (BMI) at or above the 85th percentile.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Performance Objective			24	24	21
Annual Indicator		24.2	25.6	26.3	25.7
Numerator		7579	5821	6493	7065
Denominator		31271	22749	24691	27442
Data Source					NM WIC Program
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last					

year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	24	24	24	23	23

Notes - 2008
Source: New Mexico WIC program.
Numerator: Number of WIC children age 2-5 with a BMI at or above 85%
Denominator: Number of WIC children with a valid BMI.

The method of analysis, including how the denominator was derived for 2006 and 2007 was different from 2005. It is more accurate. 2006 and 2007 should not be compared to 2005.

Notes - 2007
Source: New Mexico WIC program.
Numerator: Number of WIC children age 2-5 with a BMI at or above 85%
Denominator: Number of WIC children with a valid BMI.

The method of analysis, including how the denominator was derived for 2006 and 2007 was different from 2005. It is more accurate. 2006 and 2007 should not be compared to 2005.

Notes - 2006
Source: New Mexico WIC program.

The method of analysis, including how the denominator was derived for 2006 and 2007 was different from 2005. It is more accurate. 2006 and 2007 should not be compared to 2005.

a. Last Year's Accomplishments
Direct: Develop assessment tools to implement USDA Value Enhanced Nutrition Assessment (VENA) to connect nutrition assessment to effective/appropriate nutrition education that best meets each participant's needs. Provide in WIC Clinics statewide nutritional sessions and individual counseling on key messages using USDA materials, "FIT KIDS = HAPPY KIDS." The key messages are physical activity, decreasing TV and computer time, drinking more water and less sweetened drinks and eating as a family.

Enabling: Provide referrals to Child Medical Services, care providers and therapists in New Mexico who provide treatments to families with infants/children with feeding issues. Provide WIC clients counseling and nutritional support with food vouchers at scheduled WIC appointments.

Population-Based: Create public awareness of positive lifestyle changes and nutrition by through the NM WIC Internet site. Continue collaboration with the "The New Mexico Plan to Promote Healthier Weight" by providing information to WIC clients and the communities they live about healthful eating and physical activity.

Infrastructure: Develop a VENA tool to assess nutritional status of participants and modify WIC ADP system for data collection and evaluation. Train staff to use motivational interviewing to perform VENA assessment. Participate in the second Social Marketing evaluation of USDA materials, "FIT KIDS = HAPPY KIDS" and New Mexico state wide implementation performed by Sum Orchard marketing company.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Develop assessment tools to implement USDA Value Enhanced Nutrition Assessment (VENA) to connect nutrition assessment to effective/appropriate nutrition education that best meets each participant's needs. Provide in WIC Clinics statewide nutritional	X			
2. Provide referrals to Child Medical Services, Families First, health care providers and therapists in the State of New Mexico who provide treatments to families with infants or children demonstrating feeding issues.		X		
3. Continuing collaboration with the “The New Mexico Plan to Promote Healthier Weight” and other agencies by providing information to WIC clients and the communities they live in with the knowledge about attitudes and perceptions surrounding healthful e			X	
4. Motivational Interviewing training to all WIC staff				X
5. Implement the “Get healthier Together” Grant that was awarded by USDA that will support the Food and Nutrition Service’s initiative of Revitalizing Quality Nutrition Services in the WIC Program (RQNS). The goal of this is to improve and strengthen th				X
6. The WIC food package is being revised to include a greater variety of healthy food choices that are culturally acceptable. The WIC foods provided to families are specially designed to provide specific nutrients to help with the growth and development	X			
7.				
8.				
9.				
10.				

b. Current Activities

Direct: Develop and obtain 120 hours Nutrition Education Module that would be accessible for New Mexico WIC staff via intranet. Write policy and procedures for the training and process for training "Competent Professional Authority" (CPA) and Para-professional for the New Mexico WIC Program and submit for approval by the State Management Team.

Enabling: Continue providing referrals to Child Medical Services, health care providers and therapists in the State of New Mexico who provide treatments to families with infants or children demonstrating feeding issues. Provide WIC clients individual counseling and nutritional support with eWIC cards (food benefit) at scheduled WIC appointments.

Population-Based: Continuing collaboration with the "The New Mexico Plan to Promote Healthier Weight" and other agencies by providing information to WIC clients and the communities they live in

Infrastructure Building: Implement a Special Projects Grant that was awarded by USDA that will support the Food and Nutrition Service's initiative. The goal of this is to improve and strengthen the effectives of WIC nutrition services. NM WIC called the grant "Get Healthy Together: WIC staff and Clients Moving Toward Healthier Lifestyle". This project will replicate the staff wellness and self-efficacy training incorporated in previous Fit WIC projects. This project will implement obesity management skill training identified in and evaluated by Fit WIC projects.

c. Plan for the Coming Year

Direct: Provide individual nutrition assessment and counseling to all WIC participants at certification for the WIC Program. This includes weights and heights, nutrition assessments, and nutrition education plans for all participants. Provide to clients nutritional sessions and individual counseling on key messages. The WIC food package is being revised to include a greater variety of healthy food choices that are culturally acceptable. The WIC foods provided to families are specially designed to provide specific nutrients to help with the growth and development. The new food packages align with the 2005 Dietary Guidelines for the American and infant feeding practice guidelines of the American Academy of Pediatrics. The New Mexico WIC Program will implement the new food package by October 1, 2009.

The NM WIC staff anticipates that their discussions with WIC participants about the new foods will lead to broader conversations about the importance of a healthy lifestyle, of which healthy eating is a critical component.
Continue to implement USDA Value Enhanced Nutrition Assessment (VENA) to connect nutrition assessment to effective/appropriate nutrition education that best meets each participant's needs.

Enabling: Continue providing referrals to Child Medical Services and Families First, health care providers and therapists in the State of New Mexico who provide treatments to families with infants or children demonstrating feeding issues. Provide WIC clients individual counseling and nutritional support with food vouchers at scheduled WIC appointments.

Population-Based: Food Stamps Nutrition Education (FSNE) and WIC have partnered to provide demos and cooking classes based on the new WIC foods. A cohesive plan based on WIC's core nutrition message will be incorporated in the curriculum.

Infrastructure Building: Continue with year two of implementing Special Projects Grant that was awarded by USDA that will support the Food and Nutrition Service's initiative of Revitalizing Quality Nutrition Services in the WIC Program (RQNS). The goal of this is to improve and strengthen the effectives of WIC nutrition services. NM WIC called the grant "Get Healthy Together: WIC staff and Clients Moving Toward Healthier Lifestyle". This project will replicate the staff wellness and self-efficacy training incorporated in previous Fit WIC projects. In addition, this project will implement obesity management skill training identified in and evaluated by Fit WIC projects as important for staff's ability to provide pediatric overweight prevention and behavior management counseling.

Continue Motivational Interviewing training to all WIC staff

Performance Measure 15: *Percentage of women who smoke in the last three months of pregnancy.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective			8.5	8.5	7.2
Annual Indicator		8.5	7.6	7.6	7.6
Numerator			2129	2129	2129
Denominator			27936	27936	27936
Data Source					NM PRAMS
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and					

2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	7.2	7	7	7	7

Notes - 2008
2007 and 2008 Data are not yet available.

Notes - 2007
2007 data not yet available.

Notes - 2006
The response rate to PRAMS for 2006 was less than 70%, therefore 2006 data should be interpreted with caution.

a. Last Year's Accomplishments
July 2007 -- June 2008

Direct: Families FIRST (FF) assessed the tobacco usage of pregnant women and parents of children 0-3 statewide. FF screened for usage, offered education related to risks for mom and baby, and education about the effects of second hand smoke. FF continued to develop and implement care plans to reduce or eliminate cigarette usage, and referred clients to smoking cessation programs where available. The registered nurse and licensed social worker case managers also provided follow-up services to monitor the progress of their clients monthly for identified problems. Pregnant women's risks were re-assessed every 3 months.

The Lifelong Happiness modules were implemented by Women, Infants and Children (WIC). Training modules for this project included materials and activities to educate women regarding the avoidance of tobacco during pregnancy. The project used materials that were specific to teen clients.

NM PRAMS surveys were sent and evaluated. These surveys assessed, among other activities, cigarette usage during the last three months of pregnancy. 2000 data showed that lower income women were more likely to smoke before or during pregnancy than others. Native American or Hispanic mothers were far less likely than non-Hispanic White mothers to smoke at any time. 20-24 year-old mothers were more likely to smoke than those over 25 years of age.

WIC, Family Planning and Prenatal Care screened for tobacco usage. WIC recipients received education related to the effects of smoking on the fetus. Moms were referred to smoking cessation programs where available.

Enabling services: The Department of Health's Tobacco Use Prevention and Control Program gave almost 1700 New Mexicans free nicotine replacement patches, gum and lozenges. More than 2000 people, 8 of whom were pregnant women, called the help line during this time.

The Dee Johnson Clean Indoor Air Act began June 15, 2007. This act eliminates smoking in stores, offices, restaurants, bars and indoor public places.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**

1. Families F.I.R.S.T. will continue to provide case management for pregnant women including screening, assessment, education, care planning, referrals to smoking cessation programs and follow-up for tobacco use.	X			
2. WIC will continue to utilize their standard client history that includes assessment for tobacco use. They will provide motivational interviewing and refer as needed.	X			
3. Family Planning and Prenatal Care programs will continue to assess for tobacco usage and refer as appropriate.	X			
4. PRAMS will continue to survey for tobacco usage and report on the numbers of women who smoke in the last three months of pregnancy.	X			
5. TUPAC will continue to offer nicotine replacement services.		X		
6. The Dee Johnson Clean Indoor Air Act will eliminate smoking in stores, offices, restaurants, bars and indoor public places.		X		
7.				
8.				
9.				
10.				

b. Current Activities
July 2008 -- June 2009

Direct: The Families FIRST Program(FF) offers statewide perinatal case management to pregnant women. The women are assessed for tobacco use and second hand smoke exposure. Case Managers(CM) educate women about the harmful effects to themselves and their babies. CMs develop plans of care, provide follow-up and monitor clients' progress. Pre-term labor and compromised respiratory ailments are discussed. Referrals are made for smoking cessation classes. Case Management services are now being documented in an electronic database and reports will be generated showing the number of cases screened and the numbers of pregnant women in the FF program who are reporting the use of tobacco and or exposure to second hand smoke.

Family Planning assesses women for violence, alcohol, substance and tobacco use. Pregnant, Medicaid eligible women are referred to FF and non-Medicaid eligible women are referred to prenatal care programs. Prenatal Care programs assess for tobacco use.

Family Planning offers Lifelong Happiness, a preconception health education project including materials and activities to educate women regarding the avoidance of tobacco during pregnancy. (All educational materials are in English and Spanish)

Enabling: The DOH's Tobacco Use Prevention and Control Program (TUPAC) maintains a website with information, and reports that nicotine replacement doubles quit rates. This could reduce the State's future health care costs by $395.5 million.

c. Plan for the Coming Year
July 2009 -- June 2010

Direct: Families FIRST, WIC, Family Planning, and Prenatal Care will continue to offer the assessment, education and referral services for smoking that they are presently providing to pregnant women. WIC nutritionists will offer the Lifelong Happiness: Preconception Health Education Project modules related to smoking, and other harmful behaviors, using motivational interviewing to encourage pregnant women to reduce and quit smoking during pregnancy.

PRAMS will continue to survey women related to tobacco usage. Results produced from the FF database analysis will be evaluated to direct future educational efforts to reduce the incidence of tobacco use.

Enabling: TUPAC will continue to offer free nicotine replacement (in patches, lozenges and gum) to New Mexican tobacco users who enroll in the "Quit for Life" program. The Dee Johnson Act will continue to eliminate smoking in public places.

Performance Measure 16: *The rate (per 100,000) of suicide deaths among youths aged 15 through 19.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	13.5	13.5	13.5	13.5	21
Annual Indicator	23.9	16.5	22.8	18.5	18.5
Numerator	36	25	35	31	31
Denominator	150771	151865	153429	167360	167360
Data Source					NMVRHS analysis by MCH Epi
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	16	16	16	16	16

Notes - 2008
2008 data not yet available.

Beginning with the population estimates for 2007, the University of New Mexico Bureau of Business and Economic Research (BBER) updated its estimates of age-specific migration with new data. This change caused a break in continuity between the 2006 and 2007 estimates. Older age groups were affected more than others. For rates calculated from BBER population estimates, any rate differences from 2006 to 2007 must be interpreted with caution, as they may be partly attributable to the change in population estimates used in the rate denominators.

Notes - 2007
Future performance objectives have been raised to a more attainable level.

Beginning with the population estimates for 2007, the University of New Mexico Bureau of Business and Economic Research (BBER) updated its estimates of age-specific migration with new data. This change caused a break in continuity between the 2006 and 2007 estimates. Older age groups were affected more than others. For rates calculated from BBER population estimates, any rate differences from 2006 to 2007 must be interpreted with caution, as they may be partly attributable to the change in population estimates used in the rate denominators.

Notes - 2006
Numerator: New Mexico Vital Records and Health Statistics
Denominator: BBER

a. Last Year's Accomplishments
July 2007 -- June 2008

Direct Health Care: Family Health in partnership with OSAH continued efforts to reduce youth suicide by implementing evidenced based tools such as the Signs of Suicide (SOS) curriculum, community coalition building, screening/early identification, referral and treatment. Targeted training was provided to schools with school-based health centers on suicide crisis planning and response and a peer-to-peer program entitled "Natural Helpers" was implemented with eight schools. OSAH also supported and coordinated statewide crisis line activities. Two additional crisis lines were funded and linked to the National Talk Line (1-800-272-TALK). OSAH completed its final year of a SAMHSA funded demonstration project that incorporated eight Universal, Selective, and Indicated strategies. The initiative served four diverse rural communities and implemented screening, assessment and treatment programs for high school youth.

Enabling Services: Family Health and OSAH are partnered with inter-departmental workgroups, Value Options, and the Behavioral Health Collaborative to evaluate and recommend strategies to improve statewide behavioral health infrastructures for youth at-risk for depression and suicide through the Success in Schools committee. The redesign of New Mexico's behavioral health system created opportunities to increase interagency collaboration, assess infrastructure issues to improve the delivery of behavioral health services, and increase community collaboration focused on reducing youth suicide.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Use of NM Child Fatality review findings about suicide for policy and program planning.				X
2. Suicide prevention training in schools			X	
3. Gatekeeper training in communities			X	
4. Public and professional training sessions, educational and informational sessions are ongoing	X			
5. NM Crisis line implemented statewide and toll free	X			
6. Signs of Suicide peer based gatekeeper training in schools	X			
7. Identify youth at risk and assure access to mental health services		X		
8.				
9.				
10.				

b. Current Activities
July 2008 -- June 2009

Direct: Promote suicide prevention/intervention through schools & school-based health centers (SBHC). Technical assistance/training provided to school staff on linking school safety planning to suicide/crisis/grief planning & response. OSAH to partner with the PED to coordinate training/provide resources to increase skills, knowledge & awareness of school personnel; will continue work with the university depts. of Psychiatry & Pediatrics to expand telehealth for SBHCs, & facilitate peer-to-peer youth programs to promote awareness & resiliency.

Enabling: Partnership with inter-departmental workgroups, Optum Health & the Behavioral Health Collaborative to evaluate and recommend strategies to improve behavioral health infrastructure for youth at risk for depression and suicide.

Population: Statewide educational efforts about youth depression. Trainings on signs of suicide, crisis planning & response & reducing mental health stigma. Include behavioral health track at Head-to-Toe Conference. Partner with NM Suicide Prevention Coalition & NM Suicide Intervention Project to provide community-based awareness & crisis response.

Infrastructure: Participate in NM Child Fatality Review to monitor trends & inform policy-makers, programmers & community partners. The OSAH continues to use a health care quality initiative in SBHCs to improve infrastructure, quality of integration between primary & behavioral health care & enhancement of SBHC administrative functions.

c. Plan for the Coming Year
July 2009 -- June 2010

Direct: Family Health in partnership with OSAH will continue to promote suicide prevention and intervention through schools and school-based health centers. Technical assistance and training will be provided to school staff on the importance of linking school safety planning to suicide/crisis/grief planning and response. OSAH will work in partnership with the Public Education Department to coordinate training and resources necessary to increase skills, knowledge and awareness of school personnel on their role to reduce and address youth suicide. In addition, OSAH will continue to expand the availability of telehealth services that link school-based health centers statewide to behavioral health specialists, including psychiatrists.

Enabling: Family Health and OSAH will partner with inter-departmental workgroups, Optum Health and the Behavioral Health Collaborative to evaluate and recommend strategies to improve statewide behavioral health infrastructure for youth at risk for depression and suicide.

Population: Family Health with OSAH plans educational efforts engaging the public and professionals about youth depression. Trainings will focus on the signs of suicide, crisis planning and response among adolescent populations and reducing mental health stigma. OSAH will include a behavioral health focused track at the annual Head-to-Toe Conference, including workshops and presentations on Youth Suicide Prevention. OSAH will also continue to partner with youth suicide prevention organizations and agencies, including the New Mexico Suicide Prevention Coalition and New Mexico Suicide Intervention Project to provide community-based activities such as gatekeeper and anti-stigma awareness and training, and crisis response planning.

Infrastructure: OSAH will participate in regular DOH cross-agency workgroup meetings to address data collection and reporting on prevention activities for all age groups. The workgroup will continue to utilize data from the NM Child Fatality Review to monitor trends and to inform policy-makers, organizations and communities, program planning and policy-making. The OSAH will use a health care quality initiative in SBHCs to improve infrastructure, including increasing quality of integration between primary and behavioral health care staff; enhancement of school-based health center administrative functions needed for sustainability (ie, successful Medicaid billing and reimbursement for services.)

Performance Measure 17: *Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	70	70	70	70	70
Annual Indicator	65.2	71.3	67.6	67.6	67.6
Numerator	236	216	286	286	286
Denominator	362	303	423	423	423
Data Source					NMVRHS
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	70	70	70	70	70

Notes - 2008
2008 NMVRHS data not yet available.

Notes - 2007
2007 and 2008 delivery by facility data are not yet available.

Notes - 2006
Source: New Mexico Vital Records and Health Statistics

a. Last Year's Accomplishments
July 2007 -- June 2008

Infrastructure Building: The Maternal Health Program continued its agreement to pay University of New Mexico (UNM) Maternal-Fetal Medicine (MFM) to see high risk medically indigent women. The program is free to medically indigent women. Services are provided by MFM, nursing and social work personnel at the UNM Health Sciences Center in Albuquerque. UNM MFM held regular clinics in Albuquerque and weekly to 10 outreach clinics per month in Alamogordo, Farmington, Gallup, Roswell, Las Cruces and Indian Health Service in Albuquerque. The clinics were staffed by university perinatologists, nurses and social workers, and provided high level ultrasounds, amniocenteses and perinatology consultations. The system provided statewide access to a perinatologist 24/7 for telephone consultations and to arrange the transport of patients requiring intensive management at the university, including women in preterm labor. Maternal Health also had agreements UNM Health Sciences Center, which provided sonographic and laboratory support, and to New Mexico Sonographics, which provided sonographic support to UNM perinatology outreach clinics, with services at no cost to medically indigent clients.

Maternal Health Program continued agreements with a statewide network of 7 obstetricians, 6 hospitals and 5 sonographers in a program called the High Risk Prenatal Care Fund (HRF). The specialists provided risk-appropriate care to medically indigent women with high risk obstetric or medical conditions at no cost to the women. Through UNM and the HRF, services were accessible for medically indigent women with high-risk pregnancies wherever either high risk obstetric providers were present in the community or outreach clinics were held by UNM perinatologists. Such care prevents some low birth weight births through specialized care to the mother. These high risk providers are the most likely to anticipate and recognize preterm labor and other conditions where delivery at a tertiary care center is desirable and make appropriate transfers of care to them.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Contract with providers of high risk and low risk prenatal care to women with no other means of access.				X
2. Partner with stakeholders to upgrade staff, capacity and systems of transport.				X
3. Analyze linked birth-death data to identify gaps or disparities.				X
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
July 2008 -- June 2009

Infrastructure Building:Maternal Health Program (MH) continues agreements to pay University of New Mexico Physician Associates (UPA) to see high risk medically indigent women at no cost to the client and similar agreements for ultrasound and lab services. UPA perinatologists continue to provide 24/7 for telephone consultations and to arrange the transport of patients, including women in preterm labor. UNM MFM now provides weekly lectures by telemedicine Echo to 100 providers aroung the state on MFM topics. Maternal Health has agreements with a network of 18 providers for high-risk medically indigent women in additional locations.
A few NM residents close to neighboring states chose to deliver in those states. Women in premature labor may transfer out of the state if a tertiary care center there is closer than Albuquerque, which has the only such centers in the state. Data on which facilities these women deliver in is not available.

c. Plan for the Coming Year
July 2009 -- June 2010

Infrastructure Building: Continue to support UNM perinatology clinics and outreach programs. Continue to maximize effectiveness of the HRF, which consists of agreements with a network of high-risk prenatal care providers which obligates them to provide services for high-risk medically indigent women at no cost to the client.

Continue to improve data on gaps and disparities in transport of appropriate women to tertiary care facilities for delivery and partner with UNM perinatologists to develop strategies for improving rates of very low birth weight infants born in tertiary care centers.

Performance Measure 18: *Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2004	2005	2006	2007	2008

Annual Performance Objective	71	71	71	71	74
Annual Indicator	65.2	70.3	71.3	74.8	74.8
Numerator	18500	19590	21339	22606	22606
Denominator	28355	27862	29918	30204	30204
Data Source					NMVRHS
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	75	76	76	76	76

Notes - 2008
2008 data not yet available.

Notes - 2006
Source: New Mexico Vital Records and Health Statistics
http://www.health.state.nm.us/pdf/2006_AR_final093008.pdf

a. Last Year's Accomplishments
July 2007 -- June 2008

Infrastructure Building: The Families FIRST program continued to reach out to pregnant women in community settings and in the PHO providing case management services to pregnant women as early as possible. The program was able to add a case manager to the Dona Ana PHO site. This will potentially increase the number of women receiving early prenatal care.

The Maternal Health program continued licensing and regulating certified nurse-midwives and licensed direct-entry midwives, revising Certified Nurs Midwife (CNM) and Direct-Entry Midwife (LM) Rules to decrease barriers to practice and support national standards, and working with Health Policy Commission to find alternatives to health care liability insurance system. Spiraling rates increasingly discourage providers not covered by Tort Claims Acts from pregnancy care services.

The Program continued to support public health office prenatal clinics. It continues to provide financial support to some providers of low and high-risk care for medically indigent women The program will meet with Public Health Division's Health Systems Bureau personnel to identify strategies for increasing access to prenatal care throughout the state and collect data on services and gaps.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Provide case management to Medicaid-enrolled pregnant women, including assistance with accessing prenatal care.				X
2. License and regulate certified nurse-midwives and licensed direct-entry midwives, who provide prenatal care.				X
3. Provide support for prenatal care in local health offices to women who have no other source of care.				X

4. Administer contractual agreements with clinics to provide prenatal care for medically indigent women.				X
5. Assess access disparities, gaps and barriers to prenatal care services.				X
6. Use NM PRAMS data, Vital Records data and other information to identify key factors, gaps and disparities associated with late entry and low level of care.				X
7. Partner with state and community entities to develop and implement strategies for improving access to prenatal care.				X
8.				
9.				
10.				

b. Current Activities
July 2008 -- June 2009

Infrastructure Building: Families FIRST program is working with the PHO in Roswell to finalize the hiring of a new case manager there, is researching other potential sites, continues to provide case management services at 17 PHOs and 13 Private sites statewide.

Maternal Health Program licenses and regulates CNMs & LMs. For LMs, put in place an effective peer review system, a pharmacology course on the few drugs needed to assure safe, legal deliveries in homes, criteria for IV therapy courses, a course on optimizing the experiences of women, newborns & their families whose care is transferred to hospital/tertiary care. An updated Rule for CNMs was developed but have not had public hearings.

Continues to support prenatal care in 8 public health offices for women otherwise unable to access it, provide financial support to providers of low and high-risk care for medically indigent women, and administer the High Risk Prenatal Care Fund.

Continues work with others to propose alternatives to tort system to compensate families suffering poor birth outcomes and improving patient safety. Developed a Rule for, solicited and evaluated applications for, and made awards through a State fund of $44,000 to subsidize childbirth care providers whose practices are threatened by liability insurance fee increases. Awards of $5,000 each are being made to 7 CNMs and one OB/GYN.

Did two phone surveys to assess services and gaps in prenatal and delivery care in each county.

c. Plan for the Coming Year
July 2009 -- June 2010

Infrastructure Building: Families FIRST will finalize the hiring of a case manager in Roswell and continue to research needs and resources for expansion of the program.

Maternal Health Program plans: to finalize and enact a replacement CNM rule to reduce barriers to practice; to support prenatal care in 8 public health offices for women otherwise unable to access it; to work with other stakeholders to develop alternatives to the tort system for compensating families suffering birth injuries and improving pregnant patient safety; and to administer prescribed subsidies to a few childbirth care providers whose practices are threatened by liability insurance fee increases; and to assess and troubleshoot access problems.

D. State Performance Measures

State Performance Measure 1: *The number of New Mexico counties and tribal entities implementing positive youth development strategies defined by 6 key criteria*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Performance Objective			6	6	6
Annual Indicator			6	6	6
Numerator			6	6	6
Denominator	6	6	6	6	6
Data Source					AHP
Is the Data Provisional or Final?				Provisional	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	6	6	6	6	6

Notes - 2007
An accurate number is not currently available.

Notes - 2006
an accurate number is not currently available.

a. Last Year's Accomplishments
Updated PYD survey to CHCs and SHACs to determine progress in PYD and identify barriers. OSAH is worked with NM Forum for Youth in Community, NM Voices for Children, NM Alliance for School Based Health Care, NM Youth Alliance, NM Civic Engagement, NM Teen Pregnancy Prevention Coalition and NM Suicide Prevention Coalition to strategize how to approach the Legislature for funding the Adolescent Health Strategic Plan..

Over 250 Middle and High School students form Laguna, Shiprock and Pojoaque participated in the Native HOPE training that promotes youth empowerment, youth-adult partnerships, peer to peer health promotion, strategic planning and evaluation.

OSAH planned, coordinated, facilitated, and sponsored the Youth Development/Leadership Track at the 12th Annual Head to Toe Conference. ~100 youth from 17 schools/organizations came together to network and be trained on: teen pregnancy and youth suicide prevention, teen dating violence and healthier weight. OSAH with KUNM Radio hosted a "Youth Radio Town Hall," featuring youth from across New Mexico who shared issues young people face in their communities, how they are engaged in creating positive change and the importance of youth-adult partnership in improving adolescent health issues.

Roswell youth initiated a summit for ~80 young people after 3 young people died by suicide.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Youth Leadership Forum				X
2. Youth Health Link communication tool development			X	
3. Youth Advisory Group Project			X	
4. Support for positive youth development programs				X
5. School Health Day at the NM Legislature				X
6. 13th Annual Head to Toe Conference				X

7.				
8.				
9.				
10.				

b. Current Activities
The current activities include:

A Youth Leadership Forum - allows youth to network, share experience and concerns, develop a statewide youth agenda, all while receiving valuable tools to achieving articulated concerns.

Created and began research for the Youth Health Link, a communication tool is designed to enhance Youth Health through coordination, advocacy and leadership at all levels of NMDOH and other private and public agencies.

Support Positive Youth Development Programs activities such as: Native HOPE (Helping Our People Endure), Natural Helpers, and Teen Outreach Program (TOPs).

Implementation of the Youth Advisory Group Project- 3 Americore VISTAs have been recruited to promote positive youth development and ensure youth voice to the School Health Advisory Councils (SHAC) in Native communities.

Implementation of the 2nd Annual Indigenous Soccer Cup- promoted wellness and health promotion through a soccer tournament and health workshops. Approximately 250 Native youth attended.

Coordinated School Health Day at the NM Legislative Round focused on positive youth development. With our efforts and collaboration with the NM Forum for Youth in Community and NM Children's Cabinet, March 2-8, 2009 was proclaimed "Positive Child and Youth Development Week"

The 13th Annual Head to Toe Conference had a Youth-Adult Track (YAP) where approximately 90 youth participated and/or presented on a variety of youth health issues while partnering with adults.

c. Plan for the Coming Year
This year's activities include the following:

Research and develop a Positive Youth Development Training material that can be adapted to fit the needs of the target audience and illustrates activity at various levels of the socio-ecological model. This training material will be utilized in a training of trainers' workshop.

Development of a Native HOPE toolkit- The purpose of the toolkit is to provide resources that will simplify the process for communities and eliminate duplication of efforts. Documents will be adaptable to the communities needs. The next step will be to pilot the toolkit with a couple of communities interested in implementing Native HOPE.

Implementation of the Youth Advisory Group Project- 3 more Americore VISTAs will been recruited to promote positive youth development and ensure youth voice to the School Health Advisory Councils (SHAC) in Native communities. Evaluate the process with the existing 3 Americore VISTA's that are already in place.

The 14th Annual Head to Toe Conference will have a Prevention Track that is linked to positive youth development.

Develop and implement an Adolescent Health Survey which will provide a snapshot of adolescent health activity in NM and gather resources.

Recruit and develop work groups for the seven capacity areas of the Adolescent Health Strategic Plan which will include the steering committee.

Present at various events bringing awareness of the positive youth development approach.

Continue to provide technical assistance to support on positive youth development programs and activities, as well as promote collaboration among groups or organization that are doing similar work.

Implementation of the Youth Health Link website, a communication tool designed to enhance Youth Health through coordination, advocacy and leadership at all levels of NMDOH and other private and public agencies.

Broaden our reach to communicating with Adolescent Health key stakeholders across New Mexico.

Collaborate with planning and implementing the 3rd Annual Indigenous Soccer Cup gathering.

State Performance Measure 2: *Percent of first newborns/moms receiving support services/parenting through community home visiting/support programs*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	26	9.7	10	10	22
Annual Indicator	9.7	21.0	20.1	16.6	16.6
Numerator		3543	2096	1812	1812
Denominator		16879	10417	10893	10893
Data Source					NM PRAMS
Is the Data Provisional or Final?				Final	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	22	22	22	22	22

Notes - 2008
2008 PRAMS data not yet available.

Notes - 2007
2007 PRAMS data not yet available.

Notes - 2006
The response rate to PRAMS for 2006 was less than 70%, therefore 2006 data should be interpreted with caution.

a. Last Year's Accomplishments
July 2007 -- June 2008

Direct: Continued to provide home visiting to pregnant women and children 0-3years through the Families FIRST program (statewide), and the Parents as Teachers program n Las Cruces. Families in Las Cruces received personal visits through the Parents As Teachers program aimed at providing information, support and encouragement to parents of children from birth to three

years.
Enabling: In 2008 Title V supported a home visiting contract to provide parenting education and support services to 25 families of newborns in the city of Las Cruces.
Infrastructure Building: Partnered with state and community agencies to support other home visiting programs such as the First Born Program which has expanded their services in Grant County into three other northern NM counties. The Families FIRST program participated in a state work group which developed a plan, and produced a written report, "Building a System of Home Visiting in New Mexico" aimed at evaluating and expanding current home visiting programs.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Home visiting through Families First program	X			
2. Home visiting through the Parents as Teachers Program	X			
3. Collaboration with other state agencies to evaluate state home visiting programs and to secure continued funding for home visiting.		X		
4. Use Child Health funds to maintain the Las Cruces Home Visiting contract (Parents as Teachers)		X		
5. Continued partnership with community agencies to implement the Infant Mental Health Strategic Plan of New Mexico.		X		
6.				
7.				
8.				
9.				
10.				

b. Current Activities
July 2008 -- June 2009

Direct: Providing home visiting through the Families FIRST program (statewide), and the Parents As Teachers program in Las Cruces.

Enabling: Several staff members are participating as members of a council comprised of multiple state and private agencies that are meeting and developing a comprehensive definition of "home visiting" and reviewing both evidence based, and non-evidenced based programs that could be effective in New Mexico. We are using Child Health funds to maintain the Las Cruces Home Visiting contract. The Child Health Educator is providing staff development as needed to assure knowledge, skills, and abilities to provide Title V leadership in public health assessment, assurance, and policy development.

Infrastructure Building: Promoting best practice in primary prevention home visiting and integrating identified home visiting priorities into the work of the Early Childhood Comprehensive Systems grant.

c. Plan for the Coming Year
July 2009 -- June 2010

Direct: Provide home visiting through the Families FIRST program (statewide). Continue to fund the Parents As Teachers Program

Enabling: Utilize the Child Health Educator to continue to provide staff development as needed to assure knowledge, skills, and abilities are provided to Tile V leadership in public health assessment, assurance, and policy development. Continue to actively participate in the state work group to evaluation state home visiting programs, make recommendations for the funding of future programs and the expansion of existing programs, and develop a definition of home visiting for New Mexico.

Infrastructure Building: Continue to partner with state and community based agencies to achieve the Infant Mental Health Strategic Plan Training Goal. Promote best practice in primary prevention home visiting. Integrate identified home visiting priorities into the work of the Early Childhood Comprehensive Systems grant. Promote home visiting occurring through the Families FIRST program (statewide) and secure funding to expand the existing programs and establish future programs.

State Performance Measure 3: *Reduce unintended pregnancy in New Mexico to less than 30% of births*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	42.5	42.5	42.5	42	42
Annual Indicator	41	43.3	45.8	43.7	43.7
Numerator		19204	12763	12453	12453
Denominator		44310	27870	28477	28477
Data Source					NM PRAMS
Is the Data Provisional or Final?				Final	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	41	41	41	41	41

Notes - 2008
2008 PRAMS data is not yet available.

Notes - 2007
The 2007 PRAMS response rate was less than 70%, therefore the data should be interpreted with caution.

Notes - 2006
The response rate to PRAMS for 2006 was less than 70%, therefore 2006 data should be interpreted with caution.

a. Last Year's Accomplishments
Direct Health Care: FPP continues its efforts to increase the number of adolescents age 13-19 that receive services. The total number of adolescents aged 13- 19 seen at local public health clinics for family planning services in 2008 was 13,456, approximately 500 less clients than 2007 due to the implementation of electronic health record system in 2007 and 2008. The FPP continued expanded services in 29 Family Planning funded sites that offer flex hours that includes morning, lunch, evening and weekend hours.

Enabling Services: FPP local public health offices provide outreach through local schools (added 4 new sites), a mobile van unit, community colleges, alternative high schools, family related organizations and youth groups.

The local public health offices continue to assist clients in PE/MOSAA.

Population Based Services: Local health offices (LHOs) provided education and outreach for 5,092 clients aged 15-17 at schools, detention centers, and community centers on reproductive health topics such as abstinence, decision making skills, healthy relationships, male responsibility, parent-child communication, safer sex, sexual responsibility, teen pregnancy issues and sexually-transmitted infections.

The NM FPP funded Cooney, Watson & Associates, Inc. to conduct a survey of (primarily Hispanic) females between the ages of 15 and 35 and, subsequently, to conduct focus groups comprised of the same target group, in order to gauge their awareness and understanding of the Emergency Contraception Pill (ECP) Plan B. The purpose of the survey and subsequent focus groups was to 1) assess awareness of Plan B among this group; 2) assess the group's understanding of Plan B -- i.e. what it is, how it works, who is eligible to get it and where is it available; and 3) identify specific messages and visual triggers that participants responded to for use in future development of public awareness materials designed to target this particular group.

A total of 21 women between the ages of 15 and 35 participated in two different focus groups; the majority of these participants were Hispanic, and roughly two-thirds were Spanish-speaking (i.e., Spanish was their first language). Although there were minor differences in responses to questions posed in the two focus groups, an overwhelming majority of participants appeared to deal with the same issues, questions and concerns. For instance, ALL of the participants felt strongly that the campaign should reach out to males as well as females. A fair number of participants had concerns about Plan B being the same as the abortion pill, a misconception that will need to be dealt with in any campaign developed in the future.

Most participants responded favorably to colorful, printed materials, and almost all of them reacted positively to the small wallet-size card that could be discreetly handed to a pharmacist requesting Plan B, without actually asking for the pill in front of others.

Infrastructure Building: FPP continues to monitor quality through needs assessment, client surveys, client-centered care and electronic medical record system.

The yearly client satisfaction survey was distributed to local public health offices. In 2008 there were 1,349 clients in local public health offices took client survey (1264 females and 38 males). 664 female clients listed they had a pregnancy test done on the survey, 136 of which had a positive pregnancy test. Of the 136 positive pregnancy tests, 127 clients responded to pregnancy intendedness question; 48 (38%) wanted to be pregnant now or sooner, 63 (50%) wanted to be pregnant later and 16 (12%) did not want to be pregnant now or anytime in the future.

In 2007-2008, using CDC ‘s Win PFA software, PFA's were conducted in 35 local public health offices to establish baseline data. In 2009 two PFA's were performed in local public health offices post implementation of the electronic health record.

FPP is developing community networks. Staff from the FPP and MCH/EPI Programs consult with school health providers and youth advocates in various counties.

The NM FPP held its annual FP/STD Conference on April 23 in Ruidoso, NM and on April 24 in Albuquerque, NM with over 200 participants. Participants included clinic staff from public health offices, school based health centers, primary care clinics and administrative staff.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Increase services to hard to reach populations	X			

2. Increase the number of service sites where possible and expand hours. Services will be provided during flex hours at local health offices, clients will be served in mobile vans.	X			
3. Target outreach efforts for adolescents- offices will provide outreach through local schools, mobile van unit, community colleges, alternative high schools, family related organizations and youth groups.		X		
4. Provide outreach and education in local public health offices. Local health offices will provide educational sessions at community sites, civic organizations, and faith based sites. Teens will receive family planning education.			X	
5. Ensure quality assurances through training, client surveys and client centered care- client satisfaction survey will be distributed to local public health offices. Family planning will provide required trainings for staff.				X
6. Develop community networks- Family Planning will network with local physicians, health councils, MCH councils, faith based organizations, school-related contacts, and detention centers.				X
7.				
8.				
9.				
10.				

b. Current Activities
Direct Health Care: FPP received additional funding from Title X for hard-to-reach population in two NM counties in need of publicly-funded family planning clinical services.

Clients seen in public health offices for prenatal care during their third trimester are counseled on their postpartum contraceptive options and helped to develop a practical plan to prevent unwanted pregnancy. The nurse may dispense condoms for postpartum use as needed and may dispense up to three cycles of Progestin-only pills during the third trimester to a client who chooses them for postpartum use.

Enabling Services: The local public health offices provide outreach through local schools (2 new sites in process), a mobile van unit, community colleges, alternative high schools, family related organizations and youth groups.
PHD now has a full time Spanish translator on staff. She is available for translation of Spanish written materials as well as assessing reading levels.

Population Based Services: FPP continues to provide outreach and education in all local public health offices.

The FPP, in collaboration with NM Medicaid Family Planning Waiver Program, continue to work to develop media campaign based on the findings from surveys and focus groups. The campaign will be delivered in both English and Spanish.

Infrastructure Building: FPP continues to monitor quality through needs assessment, client surveys, client-centered care and electronic medical record system.

c. Plan for the Coming Year
Direct Health Care: FPP will continue its efforts to increase the number of adolescents age 13-19 that receive services by offering flex hours that include morning, lunch, evening and weekend hours.

Enabling: Expand services through partnering with community-based organizations and other public health providers that work with vulnerable or at-risk populations.

Population-Based: Target outreach efforts for hard-to-reach populations such as incarcerated, homeless, adolescents and males.

Provide outreach and education in local public health offices. Local public health offices provide education sessions at community & faith based sites and civic organizations.

Infrastructure Building: Ensure quality assurance through needs assessment, client surveys and clinic efficiency assessment.

Develop community networks and provide support to coalitions already in place for youth development programs and interventions.

State Performance Measure 4: *Reduce the number of children witnessing violence (exposed to domestic or sexual violence) as expressed by percent of children present at a domestic violence scene.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	13	13	13	13	20
Annual Indicator	14	18.9	22.4	18.7	18.7
Numerator		4600	4766	3184	3184
Denominator		24362	21251	17016	17016
Data Source					http://www.health.state.nm.us/pdf/DVinNewMexico200
Is the Data Provisional or Final?				Final	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	17	17	15	15	15

Notes - 2008
2008 data not yet available.

Notes - 2007
Denominator: the Number of Law Enforcement Domestic Violence Reports Documenting Status of Children Present.

Numerator: Number of Children Present at the Scene of Domestic Violence Incidents.

Source:Incidence and Nature of Domestic Violence in New mexico VIII: An Analysis of 2007 Data From the New Mexico Interpersonal Violence Data Central Retgistry.

http://www.health.state.nm.us/pdf/DVinNewMexico2007.pdf

Future performance objectives have been raised to a more attainable level.

Notes - 2006
See note for 2005.

Denominator: the number of law enforcment domestic violence reports documenting status of children present.

Numerator: The number of children present at the scene of domestic violence incidents.

Source: Incidence and Nature of Domestic Violence in New Mexico VII: An Analysis of 2006 Data From the New Mexico Interpersonal Violence Data Central Repository.

http://nmdvlc.org/pdf/Betty.Caponera.ENTIRE.DV%202006%20Report%20June%202007.pdf

a. Last Year's Accomplishments
July 2007-June 2008

Direct Health Care: The ten Sexual Assault Nurse Examiner (SANE) programs around the state continue to respond to child sexual abuse using specially trained medical providers and statewide guidelines and medical forms for consistency, SANE programs served 256 children 12 years and younger. Last year, SANE recruited over 25 new specially trained nurses and provided four conferences, three of which were specific to documentation and treatment of child sexual abuse. The South Valley Male Involvement Project (SVMIP), in partnership with the Albuquerque Public Schools, hosted a conference for youth to discuss strategies to help end violence in their communities.

Enabling Services: The statewide Network Collaborative continued to convene and address issues related to violence against women and children. This fiscal year, specific attention was focused on teen dating incidence and prevention. The New Mexico Clearinghouse on Sexual Abuse and Assault Services (NMCSAAS) continued to review and distribute materials statewide. Support continued for the Las Cruces Home Visiting Program. Work continued with Para Los Niños.

Population Based Services: Additional outreach was provided to men and male youth to educate and enroll them as part of the solution in the struggle against domestic violence by working closely with the SVMIP.

Infrastructure Building: Activities and outreach of the statewide collaborative, The Network, working to end domestic and sexual violence in NM were expanded. Work continued with the New Mexico Coalition Against Domestic Violence (NMCADV) to focus more on children witnessing violence programs. Safe Families Action Learning Lab (ALL) awarded NMDOH Maternal and Child Health and Office of Injury Prevention a two-year grant. The ALL project, a CDC-funded partnership effort between The Association of Maternal and Child Health Programs and Family Violence Prevention Fund (FVPF), began February 2007 and continued through January 2008. The goal of ALL was to integrate family violence assessment, intervention and prevention for minority women in perinatal disparities and safe motherhood programs. NM's ALL team worked to improve collaboration between the family violence and perinatal provider communities, to raise awareness of relationships between family violence and reproductive and perinatal health outcomes, to address perinatal providers' screening practices, and to raise awareness of clients at perinatal and reproductive clinics about family violence. A statewide providers meeting took place in Albuquerque to increase awareness of appropriate methods for

universal screening for lifetime exposure to violence, increase knowledge of the link between lifetime exposure to violence and reproductive health outcomes, and increase awareness of available perinatal services for family violence. FVPF provided training, and the ALL team conducted a pre- and post-test survey to assess current screening practices, knowledge and attitudes toward screening, barriers to screening, and referral patterns.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. State Early Childhood Comprehensive Systems (ECCS) grant is to assist States and territories in their efforts to build programs supporting families by offering parent education, family support, access to health insurance, and early childcare				X
2. Provide primary prevention home visiting services to Las Cruces Public School families from prenatal stage to child's third birthday with 4 program components: Home Visits, Health Promotion/Developmental Screening, Resource Network, & Group Meetings.		X		
3. Para Los Niños clinic in Albuquerque provides outreach education and prevention programming to children, professionals and communities, and also provides diagnosis and investigation of cases of child sexual abuse and sexual assault of adolescents.	X			
4. Continue to expand the activities and outreach of the statewide coalition The Network.				X
5. Continue to expand SANE programs in the state.	X			
6. Continue partnership with Office of Injury Prevention to increase awareness/knowledge of screening for lifetime exposure to violence, link between lifetime exposure to violence & reproductive health outcomes, perinatal services for family violence.				X
7.				
8.				
9.				
10.				

b. Current Activities
July 2008-June 2009

Direct: SANE sponsors 2 annual trainings/genital skills labs for new nurses, promotes cross-training among co-responding agencies, and works on the consistency of statewide operations through meetings/conferences, forms, and protocols. A training disc of 100+ injury photos to promote peer chart review and injury identification competencies was provided all SANE programs. Outreach and technical assistance was provided to new communities wanting to develop their own SANE program. A pilot effort of 3 mobile SANE kits was provided to existing SANE programs to improve their service delivery. SVMIP implements the Wise Guys curriculum to 5 schools with a chapter on dating violence. Work with Para Los Niños to provide medical evaluation + services for children + adolescents who have been sexually abused or assaulted.

Enabling: The NMCSAAS reviews and distributes materials relating to sexual assault/abuse. For the first time this year, the NMCADV received a grant to provide language, deaf, and hard of

hearing interpreter services to victims of domestic and sexual violence.

Population: SANE Programs are active with prevention information during April, Sexual Assault Awareness Month.

Infrastructure: Work with The Network to end domestic & sexual violence in NM. Work with NMCADV to focus on children witnessing violence programs. ALL continued through Jan. The 10 SANE Programs are participating in an assessment of pediatric injury knowledge and documentation competencies.

c. Plan for the Coming Year
July 2009- June 2010

Direct Health Care: SANE will continue to offer standard activities including two annual SANE training and genital skills labs and convening of SANE Task Force meetings to ensure consistency in statewide operations and long-term planning of SANE development throughout the state. Due to the loss of a grant from Albuquerque Public Schools, SVMIP will not be conducting violence prevention activities.

Enabling Services: Continue to support home visiting services through the Las Cruces Public Schools.

Infrastructure Building: Site visit assessment of the ten SANE programs in their response, protocols, equipment, and practice of the child sexual abuse and adult sexual assault exam are on-going. ALL state teams will share capacity-building experiences and lessons learned with other states and territories (through direct mentoring, conference call presentation, or a scientific meeting presentation).

State Performance Measure 5: *Increase the proportion of women who report having all six criteria of the NM Healthy Birth Index*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective			12	12	12
Annual Indicator		11.4	11.8	11.1	11.1
Numerator		4631	3035	2922	2922
Denominator		40466	25733	26327	26327
Data Source					NM PRAMS
Is the Data Provisional or Final?				Final	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	12	12	12	12	12

Notes - 2008
2008 PRAMS data not yet available.

Notes - 2007
2007 PRAMS data not yet available.

Notes - 2006
The response rate to PRAMS for 2006 was less than 70%, therefore 2006 data should be interpreted with caution.

a. Last Year's Accomplishments
July 2007 -- June 2008

Population-Based: WIC standard client history included assessment for tobacco use and alcohol use, and for folic acid awareness. Family Planning, Families FIRST and Prenatal Care program protocols and forms called for standard client assessments to include intendedness of pregnancy, alcohol, tobacco and other substance use, and domestic violence. In each program, protocols require counseling and referrals to be given to those with positive responses. WIC also provides smoking cessation classes at their various offices. WIC used training modules for women developed by Children's Medical Services' Lifelong Happiness Project, consisting of materials and activities to educate women on health measures to decrease birth defects, including folic acid use and avoidance of alcohol and tobacco.

Infrastructure Building: Family Planning distributed V.A.S.T. Guidebook 2006: Screening for Violence, Alcohol Abuse, Substance Abuse, and tobacco Use in the Public Health Setting. Families FIRST switched from a paper documentation record to an electronic documentation record. This is greatly enhancing the program's ability to obtain and analyze outcome data. It is expected to more accurately capture screenings and counseling for alcohol, tobacco, substance use and domestic violence.

Enabling: Families FIRST annual statewide meeting, which is attended by all of the program's case managers, included a guest speaker presenting on educating clients about domestic violence, domestic violence screening, and referral to community resources.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. WIC program offices provide smoking cessation classes	X			
2. Families FIRST provides case management for pregnant women of Medicaid, including assessment, referrals and follow-up for alcohol, and tobacco use.		X		
3. Pregnancy testing clinics in public health offices give prenatal vitamins with 400 mcg. folic acid to women who are pregnant/planning to become pregnant, with counseling on the importance and use of folic acid and avoidance teratogenic substances.	X	X		
4. WIC, Family Planning, Families FIRST and Prenatal Care programs' forms assess clients' substance use, folic acid awareness, pregnancy intendedness, and provide counseling and referral.			X	
5. Each of the 3 clinical contractors/19 clinics who have Provider Agreements with the Maternal Health Program are required to screen all patients for domestic violence, and substance use, and provide follow-up counseling/referrals as needed.			X	
6. Families FIRST and standard client assessments include domestic violence. In each program, protocols/guidelines direct providers to give counseling and referrals to those with positive responses.			X	
7. NM PRAMS surveys NM mothers on abuse by partner or husband before and during pregnancy.				X
8.				
9.				

10.				

b. Current Activities
July 2008 -- June 2009

Population-Based: WIC providers continue to assess clients for tobacco use and alcohol use, and for folic acid awareness. Family Planning, Families FIRST and Prenatal Care providers continue to assess clients for intendedness of pregnancy, alcohol, tobacco and other substance use, and domestic violence. Counseling and referrals are given to those with positive responses. WIC provides smoking cessation classes at their various offices and educates women on health measures to decrease birth defects, including folic acid, avoidance of alcohol and tobacco and weight control.

Infrastructure Building: Data are collected through Families FIRST's electronic client records to be analysed and used to improve the case management program's systems for helping women improve their health habits and work with their domestic violence situations and histories.

c. Plan for the Coming Year
July 2009 -- June 2010

Population-Based: WIC providers will continue to assess clients for tobacco use and alcohol use, and for folic acid awareness. Family Planning, Families FIRST and Prenatal Care providers will continue to assess clients for intendedness of pregnancy, alcohol, tobacco and other substance use, and domestic violence. Counseling and referrals will be given to those with positive responses. WIC will provide smoking cessation classes at their various offices and educate women on health measures to decrease birth defects, including folic acid, avoidance of alcohol and tobacco and weight control.

Infrastructure Building: Families FIRST program will have a complete year's worth of data collected, will complete the analysis of the data, and will use the results to improve the case management program's systems for helping women improve their health habits and work with their domestic violence situations and histories.

State Performance Measure 6: *Reduce the proportion of women who report being physically abused by husband or partner during pregnancy.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective			6.4	5	5
Annual Indicator	5.6	5.6	5.4	4.4	4.4
Numerator	1463	2506	1494	1254	1254
Denominator	26081	44635	27683	28217	28217
Data Source					PRAMS
Is the Data Provisional or Final?				Final	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	4	4	3	3	3

Notes - 2008
Plesae note that the performance objective for 2008 should be "4."

Notes - 2007

2007 PRAMS data not yet available.

Notes - 2006
The response rate to PRAMS for 2006 was less than 70%, therefore 2006 data should be interpreted with caution.

a. Last Year's Accomplishments
July 2007 -- June 2008

Enabling: Families FIRST, WIC, Family Planning and Prenatal Care program standard client assessments include domestic violence. In each program, protocols/ guidelines call for counseling and referrals to be given to those with positive responses.

Population based: Maternal Health Program agreements with each of 17 public health offices and 13 private offices, for a total of 30 clinics which provide prenatal care required them to screen all patients for domestic violence and provide follow-up counseling and referrals as needed. This represents approximately 1,550 clients.

Infrastructure Building:
NM PRAMS surveyed mothers on abuse by partner or husband before and during pregnancy.

Child Health Program and Office of Injury Prevention received a two year grant to integrate family violence assessment, intervention and prevention for minority women. The team planned a statewide training for Public Health providers on universal screening for lifetime exposure to violence, the link between lifetime exposure to violence and reproductive health outcomes, and perinatal services for family violence. Safe Families Action Learning Lab, one of the grantors, planned to provide training, and the NM team prepared a pre- and post-test survey to assess current knowledge, practices, and barriers. This grant, along with the Action Learning Lab, was available between 2007 and 2008 and the program was administered in three sties around the state during this time.

Family Planning Program distributed its V.A.S.T. Guidebook 2006: Screening for Violence, Alcohol Abuse, Substance Abuse, and tobacco Use in the Public Health Setting. It includes a Power Point presentation and a printed Guidebook, with background information on each topic, strategies to support behavior changes and for development and implementation of integrated systems for approaching V.A.S.T. issues with clients, and a bibliography.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Families FIRST and Prenatal Care program standard client assessments will continue to include domestic violence, with counseling and referrals to those with positive responses.		X		
2. Maternal Health Program will continue to include requirements to screen all patients for domestic violence and provide follow-up counseling and referrals as needed in its agreements with clinics which provide prenatal care.			X	
3. NM PRAMS will continue to survey NM mothers on abuse by partner or husband before and during pregnancy.				X
4.				
5.				
6.				
7.				

8.				
9.				
10.				

b. Current Activities
July 2008 -- June 2009

Enabling: Families FIRST, WIC, Family Planning and Prenatal Care program standard client assessments continue to include domestic violence.

Population-Based:
Maternal Health Program continues its agreements with each of 30 clinics which provide prenatal care, requiring them to screen all patients for domestic violence and provide follow-up counseling and referrals as needed. This represents approximately 1,550 clients.

Infrastructure Building:
The timeline for the perinatal intimate partner violence mini grant began February 2007 and continued through January 2008. Training was conducted in August 2007 for the partners in the Family Health Bureau, Domestic Violence Statewide and/or Regional Agencies, and the University of New Mexico. Safe Families Action Learning Lab, one of the grantors, provided the presenter, and the NM team conducted a pre- and post-test survey to assess current knowledge, practices, and barriers. Posters from Family Violence Prevention Fund were distributed along with training materials for professionals at the training to post at their offices. A report was drafted of survey findings and shared with participants and other interested parties. The overall goal for the project is to build local providers' capacity to implement universal screening for family violence and to better identify shared risk factors for reproductive health problems and violence. This grant ended with the Action Learning Lab and no longer exists.

c. Plan for the Coming Year
July 2009 -- June 2010

Enabling: Families FIRST, WIC, Family Planning and Prenatal Care program standard client assessments will continue to include domestic violence. In each program, protocols/ guidelines call for counseling and referrals to be given to those with positive responses. NM PRAMS will continue to survey mothers on abuse by partner or husband before and during pregnancy.

Population Based:
Maternal Health Program agreements with each of 21 clinics which provide prenatal care required them to screen all patients for domestic violence and provide follow-up counseling and referrals as needed. This represents approximately 1,200 clients.

The First Born home visiting program will begin to screen for domestic violence through a Project Launch grant. This program, which focuses on the physical, emotional and mental well-being of children 0-8 years, is now operating in three school districts within Santa Fe County.

Infrastructure Building: NM PRAMS will continue to survey mothers on abuse by partner or husband before and during pregnancy.

Family Planning Program distributed its V.A.S.T. Guidebook 2006: Screening for Violence, Alcohol Abuse, Substance Abuse, and tobacco Use in the Public Health Setting. It includes a Power Point presentation and a printed Guidebook, with background information on each topic, strategies to support behavior changes and for development and implementation of integrated systems for approaching V.A.S.T. issues with clients, and a bibliography. Parts of this handbook are still being used in programs, but it is currently in the process of being updated. Additionally, a

version specific to WIC clients is being made in collaboration with the VAST committee and WIC.

State Performance Measure 8: *Increase the proportion of women who deliver a live infant who are reported to have been screened for syphilis during pregnancy.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Performance Objective				89	89
Annual Indicator		89	75.6	75.6	75.6
Numerator			22042	22042	22042
Denominator			29163	29163	29163
Data Source					NMVRHS
Is the Data Provisional or Final?				Provisional	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	90	90	90	90	90

Notes - 2008
NMVRHS converted to a new electronic birth certificate in 2008 and current syphilis screening information will be available when that data becomes available.

Notes - 2007
There were 41 cases of primary, secondary and early latent syphilis reported for women aged 15-44 for 2006. The number of pregnant women screened during that year is not currently available.

http://www.nmhealth.org/std/pdf/PrimarySecondaryEarlyLatentSyphilisAgeSexCounty.pdf

In 2007, among women aged 10-54, there were a total of 39 cases of Syphilis.

15 cases of primary and secondary syphilis
24 cases of early-latent syphilis.

http://www.health.state.nm.us/std.html

Notes - 2006
Source: New Mexico Vital Records and Health Statistics.

Numerator: The number of women giving live birth in 2006 that were screened for syphilis

Denominator: The number of women giving live birth in 2006.

a. Last Year's Accomplishments
July 2007 -- June 2008

Population-Based:

Data from the STD Program, Infectious Disease Bureau indicated that in 2006 there were 7 identified cases of congenital syphilis (CS), giving NM a rate of 2.5 cases per 10,000 live births, well above the 2005 national rate of <1 per 10,000 live births. Congenital syphilis is associated with fetal death, and in those who survive, vision and hearing loss, bone changes and developmental disabilities.

Effective prevention and detection of congenital syphilis depends on the identification of syphilis in pregnant women and, therefore, on the routine serologic screening of pregnant women during

the first prenatal visit. In communities and populations in which the risk for congenital syphilis is high, serologic testing and a sexual history also should be obtained at 28 weeks' gestation and at delivery.

Data from the Bureau of Vital Records and Health Statistics birth file indicate that between 1990 and 2005, the percent of women delivering a live infant who were reported to have been screened for syphilis, decreased from 96% in 1990 to less than 89% in 2005. During this same time the incidence of congenital syphilis has been increasing. Both the proportion of pregnant women who were not screened increased (from 2.8% in 1990 to 6.5% in 2005) and the proportion of women for whom syphilis screening was not reported increased (from 1.7% to 5.2%).

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Test women in DOH prenatal clinics on entry to prenatal care and at 28 weeks gestation. Provide counseling treatment and follow-up for positive-testing women	X			
2. With provider partners, develop strategies to address the barriers identified.			X	
3. Assess the barriers to syphilis testing, follow up and treatment for pregnant women.				X
4. Inform providers of the rising presence of CS, and the requirements and recommendations for reducing it; encourage and assist them to troubleshoot potential systems problems.				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
July 2008 -- June 2009

Direct: Maternal Health Program changed its syphilis testing protocols on repeat syphilis screening at 28 weeks gestation from women at high risk to all women.
Population-Based: The programs of Maternal Health, Sexually Transmitted Diseases (STD), and Border Health are working with providers to develop strategies to encourage testing all pregnant women.

Infrastructure: A review of all known cases of congenital syphilis in New Mexico identifies the key problems to be lack of prenatal care, lack of screening for syphilis, lack of reporting, women discharged from hospitals before tests are reported and being lost to follow-up, & inadequate treatment for mother and newborn. An epidemiologist was sent to alert hospitals and staff in the most affected counties to the systems problems, rise in CS rates, the CDC's guidelines for testing/treatment of syphilis and state rules for testing for and reporting syphilis. Hospitals' systems for testing, reporting, treatment and follow-up were reviewed and potential loopholes were addressed.

Maternal Health Program also wrote letters to the current chair of the New Mexico ACOG chapter, the head of maternal/fetal medicine at University of New Mexico (UNM), and directors of the family practice and nurse-midwifery programs at UNM, notifying them of the above,

requesting that they convey all of the information to their students, staff and colleagues, and that they troubleshoot potential systems problems and UNM hospital.

c. Plan for the Coming Year
July 2009 -- June 2010

The Maternal Health Program continues the Prenatal Protocol requirement that all pregnant women be screened for syphilis at 28 weeks gestation. According to the NM STD Program all reported cases of syphilis in pregnancy are investigated.

Population-Based: The Department of Health Programs (Maternal Health, STD, Border Health) will work with providers throughout to develop strategies to facilitate the testing of all pregnant women.

Infrastructure Building: We will continue to assess and identify the key barriers to syphilis testing, reporting, treatment and follow-up on pregnant women. Based on this assessment, we will work with partners to develop the means to address each one. We continue to monitor the percent of women reported to have been tested on the birth file. STD program continues to provide follow up for all suspected women with syphilis and infants with congenital syphilis.

E. Health Status Indicators

Introduction

/2010/The key issues that affect the health of the MCH population are the high rate of poverty in the state and the disproportionate burden of coping with less social advantage, particularly among minority groups who make up the majority of this population. Gaps and disparities are seen consistently among teens, parents with only a high school education or less, and single parents. These characteristics translate into greater proportions of health risk behaviors, and lower access to and use of primary preventive care or specialty care. Although the state has made progress in reducing the proportion of the population that has no health insurance, critical gaps persist. There is a significant challenge in assuring access to care for the working poor and immigrant families who come into the state -- many who pay taxes on their income.//2010//

Health Status Indicators 01A: *The percent of live births weighing less than 2,500 grams.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Indicator	8.1	8.5	8.9	8.7	8.7
Numerator	2304	2493	2724	2722	2722
Denominator	28355	29256	30567	31174	31174
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2008

2008 NMVRHS data are not yet available.

Notes - 2007
Source: NMVRHS, Analysis by MCH Epidemiology.

Notes - 2006
Source: NMVRHS, Analysis by MCH Epidemiology.

Narrative:
/2010/The 2006 multiple birth rate, defined as the number of twins, triplets, or higher order multiple births per 1,000 total live births, was 25.2 in New Mexico. The New Mexico rate was lower than the national rate each year since 2002. In 2005, the multiple birth rate in New Mexico (25.6) was 24.3% lower than that of the United States.

Birthweight is an important predictor of infant survival. Low birth weight is a factor in approximately two-thirds of infant deaths nationally. Low birthweight newborns are also more likely to have serious health problems and increased risks of long-term disabilities.

In New Mexico, from 2002-2006, White mothers had the highest rate of multiple births. Mothers ages 40 to 49 had the highest rate of multiple births among age groups.

The percent of low birthweight infants in the United States reached a high of 8.2% in 2005. In New Mexico, the percent of low birthweight infants increased from 8.5% in 2005 to 8.9% in 2006. Since 1990, the proportion of low birthweight infants has increased in New Mexico and nationally. Approximately half of New Mexico's counties had higher than the New Mexico percentage of low birthweight births of 8.5%. The Northeast Region and Bernalillo County had higher proportions of low birthweight infants than the state as a whole.//2010//

Health Status Indicators 01B: *The percent of live singleton births weighing less than 2,500 grams.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	6.8	7.2	7.6	7.3	7.3
Numerator	1890	2058	2245	2203	2203
Denominator	27677	28518	29714	30369	30369
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2008
2008 NMVRHS data not yet available.

Notes - 2007
Source: NMVRHS, Analysis by MCH Epidemiology.

Notes - 2006
Source: NMVRHS, Analysis by MCH Epidemiology.

Narrative:
/2010/Nationally, demographic factors associated with increased risk of low birthweight include mother's age (17 years and younger or 35 years and older), marital status of the mother (single), and gestational age. For mothers less than 20 years of age the national figures showed a higher proportion of low birthweight births while for mothers 20 years or older New Mexico had higher proportions of low birthweight births. For infants weighing 1500-2499 grams, 16.8% were born to mothers ages 15-19 and 28.2% were born to mothers ages 30 and over. Of preterm births (births that occurred before the 37th week of pregnancy), 45.9 % were low birthweight infants.

At 80.2%, most live births were "term" (born at 37-41 weeks gestation) in 2006. The percentage of preterm births (under 37 weeks) increased from 10.2% in 2002 to 11.1% in 2006. Preterm birth is a leading cause of infant death and is associated with congenital neurological defects. Preterm births were highest in Black or African American (15.0%) and American Indian or Alaska Native (12.6%) populations in 2006. Most of the preterm births were infants born at 32 to 36 weeks of gestation.

The recent increase in births by elective and repeat cesarean section (scheduled cesarean section) contributes to the rate of late preterm births, which constitute a large proportion of low birth-weight babies, as there are no perfectly accurate predictors of fetal weight or gestational age against which to plan a delivery. Similarly, the increase in elective and scheduled inductions contribute to the cesarean section rate, late preterm births and low birth-weight babies. A third rising risk factor for low birth weight is the increase in type 2 diabetes. Babies of type 2 diabetic mothers are at increased risk of being low birth-weight. New Mexico's strategic plan for health is strongly focused on reducing obesity and diabetes. It is expected that in the long term, this will at least slow the increase in low birth-weight. In addition, New Mexico continues to support and expand the proportion of mothers delivered by nurse-midwives and other midwives, whose services have been demonstrated to produce significantly fewer low-birth weight babies, perhaps partly due to their focus on prevention and nutrition, as well as much less use of interventions. Recent studies have shown that women with severe periodontal disease are at significantly increased for preterm birth. New Mexico has a sever shortage of dentists, and very few of those practicing are willing to see women covered by Medicaid Public Health Division's Oral Health Program is actively contracting with dental hygienists and dentists to see Medicaid-covered pregnant women. Dental Hygienists are now allowed to see patients independently if they refer their patients to be seen by a dentist once a year. This new freedom will extend services to many Medicaid-covered pregnant women.//2010//

Health Status Indicators 02A: *The percent of live births weighing less than 1,500 grams.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	1.3	1.3	1.4	1.3	1.3
Numerator	362	369	434	417	417
Denominator	27797	29256	30567	31174	31174
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year					

moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2008
2008 NMVRHS data not yet avaiailable.

Notes - 2007
Source: NMVRHS, Analysis by MCH Epidemiology.

Notes - 2006
Source: NMVRHS, Analysis by MCH Epidemiology.

Narrative:
/2010/In 2006, of the 423 very low birthweight infants, 17.7% were born to mothers ages 15-19 and 31.5% were born to mothers ages 30 and over. In 2005, New Mexico ranked 15th along with seven other states in the percent of very low birth weight babies born. In 2006, according to NM State Center for Health Statistics, 423 out of 29,918, or 1.41% babies were born weighing less than 1,500 grams. Almost all very low birth-rate babies are premature, though they may also be growth restricted. Efforts to decrease the percent of live births weigning less than 1,500 grams, therefore, focus on prevention of premature births. In addition, it is important when possible for very low birth weight babies to be born in tertiary care centers where they can receive appropriate care. Even so, these babies are at very high risk for neonatal death and for long-term disease and disabilities. Reliable strategies for stopping preterm labor until the fetus is mature have not been found. Strategies for preventing preterm labor as well as growth restriction include preconception care, smoking prevention and cessation, drug abuse prevention and cessation, inimate partner violence preventation, nutritional support.//2010//

Health Status Indicators 02B: *The percent of live singleton births weighing less than 1,500 grams.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	1.0	1.0	1.1	1.0	1.0
Numerator	276	289	324	316	316
Denominator	27677	28518	29714	30369	30369
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2008
2008 NMVRHS data not yet available.

Notes - 2007
Source: NMVRHS, Analysis by MCH Epidemiology.

Notes - 2006
Source: NMVRHS, Analysis by MCH Epidemiology.

Narrative:
/2010/In 2006, there were 316 very low birth weight singleton births, and they comprised 75% of births weighing less than 1,500 grams. There were 48 pairs of twins, comprising 23%; two sets of triplets; and one set of quintuplets. High orders of plural gestations are commonly associated with assisted reproductive technology. It seems likely that the quintuplets, and possibly the triplets and some of the twins, could have been avoided if fertility specialists followed the policies of the American Society for Reproductive Medicine and limited the numbers of embryos transferred into an assisted woman's uterus to two. This possibility of encouraging or enforcing such policies should be pursued in New Mexico.//2010//

Health Status Indicators 03A: *The death rate per 100,000 due to unintentional injuries among children aged 14 years and younger.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	12.2	11.7	10.9	6.9	6.9
Numerator	50	48	45	28	28
Denominator	411488	409523	411065	405808	405808
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2007
Numerator: NMVRHS Analysis by MCH Epidemiology
Denominator: BBER

Beginning with the population estimates for 2007, the University of New Mexico Bureau of Business and Economic Research (BBER) updated its estimates of age-specific migration with new data. This change caused a break in continuity between the 2006 and 2007 estimates. Older age groups were affected more than others. For rates calculated from BBER population estimates, any rate differences from 2006 to 2007 must be interpreted with caution, as they may be partly attributable to the change in population estimates used in the rate denominators.

Notes - 2006
Numerator: NMVRHS Analysis by MCH Epidemiology
Denominator: BBER

Beginning with the population estimates for 2007, the University of New Mexico Bureau of Business and Economic Research (BBER) updated its estimates of age-specific migration with new data. This change caused a break in continuity between the 2006 and 2007 estimates. Older age groups were affected more than others. For rates calculated from BBER population estimates, any rate differences from 2006 to 2007 must be interpreted with caution, as they may be partly attributable to the change in population estimates used in the rate denominators.

Narrative:
/2010/According to the the National Center for Injury Prevention and Control's WISQARS Injury Mortality Reports, from 2003-2006, 197 children under the age of 14 died from

unintentional injuries, for a crude rate of 12.04.

The key causes of injury death differ by age. Understanding this helps target prevention efforts toward key causes of injury in each age group. Injuries are the leading cause of death in children and young adults--the healthiest segment of our population. Motor vehicle crashes are the most frequent cause of injury death for every age group under 24. Drowning is a leading cause of injury death for children 9 years and younger. Other land transport, which includes bicycle-related injuries, is a major cause of injury death for children ages 5-14.

Title V funds support a full time childhood injury prevention coordinator position in the office of injury prevention. Efforts by the childhood injury prevention coordinator and the injury prevention team led to the enactment of a recreational helmet law effective 7/01/2007, requiring children under 18 years on bicycles, skateboards, skates and scooters to wear helmets when riding on public roads and parks.

The New Mexico Safe Kids Coalition is purchasing ~$30,000 worth of helmets and distributing them to the SAFE KIDS network as part of the implementation campaign for the new helmet law. The NMSKC is increasing its collaboration with NMDOT, PED, CYFD and many nonprofits to implement the Child Helmet Safety Act statewide in every community. Partnership with the nonprofit Brain Injury Association to administer the NMSKC is being considered. A "Safe Skate Park Campaign" and a "Safe Sleep Campaign" are being initiated this year. The SAFE KIDS network is being expanded from 12 to 16 locations. Grant, Dona Ana, Chaves, Sandoval, Rio Arriba and Taos Counties are planning SAFE KIDS chapters. A statewide New Mexico SAFE KIDS Coalition budget, funded by the Children's Cabinet, will not be introduced at the 2009 Legislature because of lack of funding. The intent was to provide a permanent state allocation of $100,000 - $300,000 to purchase and distribute child car seats, non-motorized vehicle helmets, and smoke alarms for events produced by SAFE KIDS coalitions. A portion of the funding was to be used to train home inspectors for the new First Born program, which provides 6-12 home visits per year for two years to new parents. A $150,000 grant proposal to the New Mexico Automobile Dealers Association was also rejected due to the collapse of the automobile sales market, and the subsequent lack of grant funds available.//2010//

Health Status Indicators 03B: *The death rate per 100,000 for unintentional injuries among children aged 14 years and younger due to motor vehicle crashes.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	7.3	8.1	6.6	6.4	6.4
Numerator	30	33	27	26	26
Denominator	411488	409523	411065	405808	405808
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2008
2008 data not yet available.

Notes - 2007
Numerator: NMVRHS
Denominator: BBER
Analysis by MCH Epidemiology.

Beginning with the population estimates for 2007, the University of New Mexico Bureau of Business and Economic Research (BBER) updated its estimates of age-specific migration with new data. This change caused a break in continuity between the 2006 and 2007 estimates. Older age groups were affected more than others. For rates calculated from BBER population estimates, any rate differences from 2006 to 2007 must be interpreted with caution, as they may be partly attributable to the change in population estimates used in the rate denominators.

Notes - 2006
Numerator Source: New Mexico 2006 Traffic Crash Information Report: http://www.unm.edu/~dgrint/dgr.html

Denominator Source: University of New Mexico Bureau of Business and Economic Research 2006 intercensal estimate.

Beginning with the population estimates for 2007, the University of New Mexico Bureau of Business and Economic Research (BBER) updated its estimates of age-specific migration with new data. This change caused a break in continuity between the 2006 and 2007 estimates. Older age groups were affected more than others. For rates calculated from BBER population estimates, any rate differences from 2006 to 2007 must be interpreted with caution, as they may be partly attributable to the change in population estimates used in the rate denominators.

Narrative:
/2010/According to the National Center for Injury Prevention and Control's WISQARS Injury Mortality Reports, from 2003-2006, 119 children aged 0-14 died as a result of a motor vehicle crash. The age-adjusted rate for that time period was 7.27. Motor vehicle crashes are the most frequent cause of injury death for every age group under 24. Over 500 children age 14 and younger, were injured in motor vehicle crashes in 2005, and 33 children died.

New Mexico ranked 10th highest among states in seatbelt use in 2005 with 89.5% of front seat occupants wearing seatbelts From 1983 to 1995, New Mexico seatbelt use increased dramatically and then continued a gradual increase to nearly 90% usage. In this period crash deaths decreased 30%. New Mexico enacted a booster seat law in 2005.

According to the 2005 New Mexico Youth Risk and Resiliency Survey: 80% of high school students reported seatbelt use most or all the time. More than 30% of both male and female students reported that, in the past 30 days, they had ridden with a driver who had been drinking.

MVC death rates and alcohol involved MVC death rates have decreased by 35% and 59%, respectively, from 1982 to 2004. Alcohol was involved in 10% of all MVCs causing injury or death in 2004. Forty-two percent of motor vehicle injury deaths in 2004 occurred in alcohol-involved crashes.

Several Key interventions have been implemented to reduce MVC deaths, including vehicle and roadway design improvement, increased seat-belt use, standard airbags in cars, new DWI laws, and ignition interlock laws.

The New Mexico Safe Kids Coalition network will continue to collaborate with Safer New Mexico Now (SNMN) on the training of child car seat technicians and production of child

car seat clinics.//2010//

Health Status Indicators 03C: *The death rate per 100,000 from unintentional injuries due to motor vehicle crashes among youth aged 15 through 24 years.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	41.8	39.2	35.9	33.6	33.6
Numerator	126	119	111	107	107
Denominator	301543	303556	309204	318276	318276
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2007
Numerator: NMVRHS
Denominator: BBER
Analysis by MCH Epidemiology.

Beginning with the population estimates for 2007, the University of New Mexico Bureau of Business and Economic Research (BBER) updated its estimates of age-specific migration with new data. This change caused a break in continuity between the 2006 and 2007 estimates. Older age groups were affected more than others. For rates calculated from BBER population estimates, any rate differences from 2006 to 2007 must be interpreted with caution, as they may be partly attributable to the change in population estimates used in the rate denominators.

Notes - 2006
Numerator Source: New Mexico 2006 Traffic Crash Information Report: http://www.unm.edu/~dgrint/dgr.html

Denominator Source: University of New Mexico Bureau of Business and Economic Research 2006 intercensal estimate.

Beginning with the population estimates for 2007, the University of New Mexico Bureau of Business and Economic Research (BBER) updated its estimates of age-specific migration with new data. This change caused a break in continuity between the 2006 and 2007 estimates. Older age groups were affected more than others. For rates calculated from BBER population estimates, any rate differences from 2006 to 2007 must be interpreted with caution, as they may be partly attributable to the change in population estimates used in the rate denominators.

Narrative:
/2010/According to the National Center for Injury Prevention and Control's WISQARS Injury Mortality Reports, from 2003-2006, 480 youth aged 15 through 24 died as a result of a motor vehicle crash. The age-adjusted rate for this period was 41.03.

In 2005, 15% percent of all drivers in crashes were young adult drivers, although young adults comprised only nine percent of NM drivers. Twenty eight percent of crashes involving young adult drivers occurred at night, while only 26 percent of all crashes

occurred at night. (Source: Division of Government Research, UNM, Traffic Safety Bureau)

Overall, New Mexico ranked 10th highest among states in seatbelt use in 2005 with 89.5% of front seat occupants wearing seatbelts From 1983 to 1995, New Mexico seatbelt use increased dramatically and then continued a gradual increase to nearly 90% usage. In this period crash deaths decreased 30%.

MVC death rates and alcohol involved MVC death rates have decreased by 35% and 59%, respectively, from 1982 to 2004. Alcohol was involved in 10% of all MVCs causing injury or death in 2004. Forty-two percent of motor vehicle injury deaths in 2004 occurred in alcohol-involved crashes.

According to the 2005 New Mexico Youth Risk and Resiliency Survey: 80% of high school students reported seatbelt use most or all the time. More than 30% of both male and female students reported that, in the past 30 days, they had ridden with a driver who had been drinking.

Several Key interventions have been implemented to reduce MVC deaths, including vehicle and roadway design improvement, increased seat-belt use, standard airbags in cars, new DWI laws, and ignition interlock laws.//2010//

Health Status Indicators 04A: *The rate per 100,000 of all nonfatal injuries among children aged 14 years and younger.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	197.1	173.6	173.8	173.8	173.8
Numerator	825	711	769	769	769
Denominator	418488	409523	442462	442462	442462
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

Notes - 2007
See note for 2006.

Hospital Discharge Data 2007 is not yet available.

Notes - 2006
Note 7/08:

The 2006 rate is for children ages 15 and younger; that is the age category that was available from the Health Policy Commission for this year.

Numerator Source: New Mexico Health Policy Comission. Analysis by the Office of Injury Prevention, Epidemiology and Response Division, NM DOH.

Denominator Source: UNM Bureau of Business and Economic Research
2006 intercensal estimate.

Beginning with the population estimates for 2007, the University of New Mexico Bureau of Business and Economic Research (BBER) updated its estimates of age-specific migration with new data. This change caused a break in continuity between the 2006 and 2007 estimates. Older age groups were affected more than others. For rates calculated from BBER population estimates, any rate differences from 2006 to 2007 must be interpreted with caution, as they may be partly attributable to the change in population estimates used in the rate denominators.

Narrative:
/2010/Injuries are the leading cause of hospitalization in young children and youth. Injury prevention for children age 0-4 requires strategies to educate parents and others who care for young children. Home visiting for parents of 0-3 year old children is a critical need. There is no substitute for a home visit that includes an injury prevention "safety check" that covers many forms of injury, including accidental poisonings. A safety check can have an impact for parents for many years -- leading to safer homes for children. The "teachable moment" is a venue for injury prevention for children age 5 and older is greatly expanded beyond the home. While adults continue to be responsible for supervision of children -- guardians for their safety -- young children can learn basics of safety in day care and school, and other places where children gather.

In 2006, the rate per 100,000 of all non-fatal injuries among children aged 15* years and younger f was 173.8/100,000 representing 769 non-fatal injuries for children in that age group. This is a rate and injury decrease from 2003 when the rate was 197.1 and number was 825.

Children under 14 years are five times more likely to be injured in bicycle-related crashes than older riders. According to the NM Brain Injury Advisory Council, between 70% and 80% of all fatal bicycle crashes involve brain injuries Nationally, only 41% of kids ages 5 to 14 wear helmets when participating in wheeled activities like biking and skateboarding, and 35% of children who use helmets wear them improperly. Bicycle helmets have been shown to reduce the risk of head injury by as much as 85% and the risk of brain injury by as much as 88%. In states with mandatory bicycle helmet laws, TBI has been reduced by 45% The rate of hospitalization for bicycle-related injuries is 2.6% higher for children 17 and younger compared to adults. In July, 2007, NM enacted a recreational helmet law requiring children under 18 years on bicycles, skateboards, skates and scooters to wear helmets when riding on public roads and parks.

Childhood Injury Prevention includes promoting policies and programs that support the prevention of motor vehicle injury, non-motorized vehicle injury, pedestrian injury, day care injury, school injury, and sports injury. Prevention strategies include the development of nonprofit, public agency, school and internet-based curricula and materials for parents, youth, community educators, health care professionals, home and commercial day care providers, policemen, firemen and home visitation specialists. Other prevention strategies include technical support of state/local coalitions, boards and other organizations involved in childhood injury prevention, including the NM SAFE KIDS Coalition, the NM Helmets for Kids Coalition, and the Off Highway Vehicle Safety Board, and sharing of evidence-based prevention programs, research, networking, and funding opportunities for childhood injury prevention programs.//2010//

Health Status Indicators 04B: *The rate per 100,000 of nonfatal injuries due to motor vehicle crashes among children aged 14 years and younger.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	580.1	187.8	510.1	510.1	510.1
Numerator	2387	769	2097	2097	2097
Denominator	411488	409523	411065	411065	411065
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

Notes - 2007
2007 & 2008 Vehicle Crash Injury Data are not yet available.

Beginning with the population estimates for 2007, the University of New Mexico Bureau of Business and Economic Research (BBER) updated its estimates of age-specific migration with new data. This change caused a break in continuity between the 2006 and 2007 estimates. Older age groups were affected more than others. For rates calculated from BBER population estimates, any rate differences from 2006 to 2007 must be interpreted with caution, as they may be partly attributable to the change in population estimates used in the rate denominators.

Notes - 2006
Note: the number for 2005 is incorrect. It should be 2250 children 14 and younger that were injured in a motor vehicle crash for a rate of 549.4 per 100,000.

Numerator Source: New Mexico 2006 Traffic Crash Information Report:
http://www.unm.edu/~dgrint/dgr.html

Denominator Source: University of New Mexico Bureau of Business and Economic Research 2006 intercensal estimate.

Beginning with the population estimates for 2007, the University of New Mexico Bureau of Business and Economic Research (BBER) updated its estimates of age-specific migration with new data. This change caused a break in continuity between the 2006 and 2007 estimates. Older age groups were affected more than others. For rates calculated from BBER population estimates, any rate differences from 2006 to 2007 must be interpreted with caution, as they may be partly attributable to the change in population estimates used in the rate denominators.

Narrative:
/2010/In 2006, 2,097 children under the age of 14 were injured in motor vehicle crashes.

New Mexico is working on traffic safety matters on a number of fronts. State and federally funded programs such as statewide driver education, DWI driving schools, selective traffic enforcement projects, operation DWI, operation buckle down, Super Blitz checkpoints and saturation patrols, pedestrian safety, motorcycle safety, and related law enforcement training programs are framing the attitudes and beliefs of the driving public. Our partners, state and local government agencies, non-profi t organizations, legislators, and law enforcement agencies are responsible for the successful changes and safer New Mexico roadways.

A statewide New Mexico SAFE KIDS Coalition budget, funded by the Children's Cabinet, will not be introduced at the 2009 Legislature because of lack of funding. The intent was to provide a permanent state allocation of $100,000 - $300,000, some of which would have been used to purchase and distribute child car seats.//2010//

Health Status Indicators 04C: *The rate per 100,000 of nonfatal injuries due to motor vehicle crashes among youth aged 15 through 24 years.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	2,486.9	2,212.1	2,009.4	2,009.4	2,009.4
Numerator	7499	6715	6213	6213	6213
Denominator	301543	303556	309204	309204	309204
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

Notes - 2007
2007 traffic crash data are not yet available.

Beginning with the population estimates for 2007, the University of New Mexico Bureau of Business and Economic Research (BBER) updated its estimates of age-specific migration with new data. This change caused a break in continuity between the 2006 and 2007 estimates. Older age groups were affected more than others. For rates calculated from BBER population estimates, any rate differences from 2006 to 2007 must be interpreted with caution, as they may be partly attributable to the change in population estimates used in the rate denominators.

Notes - 2006
Numerator Source: New Mexico Traffic Crash Information Report:
http://www.unm.edu/~dgrint/dgr.html

Denominator Source: University of New Mexico Bureau of Business and Economic Research 2006 intercensal estimate.

Narrative:
/2010/In 2006, 6,213 youth aged 15-24 were injured due to motor vehicle crashes, for a rate of 2009.4 per 100,000.

Fifteen percent of all drivers in crashes were young adult drivers, although young adults comprised only nine percent of NM drivers. Twenty eight percent of crashes involving young adult drivers occurred at night, while 26 percent of all crashes occurred at night.

Overall, New Mexico ranked 10th highest among states in seatbelt use in 2005 with 89.5% of front seat occupants wearing seatbelts From 1983 to 1995, New Mexico seatbelt use increased dramatically and then continued a gradual increase to nearly 90% usage. In this period crash deaths decreased 30%.

New Mexico is working on traffic safety matters on a number of fronts. State and federally funded programs such as statewide driver education, DWI driving schools, selective traffic enforcement projects, operation DWI, operation buckle down, Super Blitz checkpoints and saturation patrols, pedestrian safety, motorcycle safety, and related law enforcement training programs are framing the attitudes and beliefs of the driving public. Our partners, state and local government agencies, non-profi t organizations, legislators, and law enforcement agencies are responsible for the successful changes and safer New Mexico roadways.//2010//

Health Status Indicators 05A: *The rate per 1,000 women aged 15 through 19 years with a reported case of chlamydia.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	33.9	31.5	36.7	30.2	30.2
Numerator	2495	2335	2750	2469	2469
Denominator	73555	74172	75026	81814	81814
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2008
2008 data are not yet available.

Notes - 2007
Numerator Source: NM DOH STD program
http://www.health.state.nm.us/std/pdf/ChlamydiaCasesAgeSexCounty07.pdf

Denominator Source: UNM Bureau of Business and Economic Research 2007 population estimate

Beginning with the population estimates for 2007, the University of New Mexico Bureau of Business and Economic Research (BBER) updated its estimates of age-specific migration with new data. This change caused a break in continuity between the 2006 and 2007 estimates. Older age groups were affected more than others. For rates calculated from BBER population estimates, any rate differences from 2006 to 2007 must be interpreted with caution, as they may be partly attributable to the change in population estimates used in the rate denominators.

Notes - 2006
Numerator Source: NM DOH STD program
http://www.health.state.nm.us/std/pdf/ChlamydiaCasesAgeSexCounty.pdf

Denominator Source: UNM Bureau of Business and Economic Research 2006 population estimate.

Narrative:

/2010/In 2007, there were 2,469 cases of Chlamydia among females, and 564 among males. In 2008, the FPP tested 1,581 females and 240 males for chlamydia. The Family Planning Program (FPP) Protocol recommends annual screening for all sexually active women ages 25 and under. In addition, the protocol recommends chlamydia screening in pregnant women, women seeking intrauterine device insertion and any woman who is a known contact to a partner with gonorrhea, chlamydia, or non-gonococcal urethritis

According to the YRRS 2007, 45.7% of New Mexico high school students had "ever" had sexual intercourse, while almost one third of students (31.5%) reported being currently sexually active. Students who were currently sexually active increased with grade level.

The Navajo YRRS reports that in 2003 40% of Navajo high school students reported ever having sexual intercourse, while 11% reported having sex with four or more partners.13 Of the students that were currently sexually active, 52% reported using a condom during last intercourse. The number of Chlamydia cases has increased over time in all age groups for both males and females within New Mexico. There were just over 1,500 cases in 15-19 year old females in 1999, and that has steadily increased to 2,500 in 2007.

The chlamydia testing in the FPP-funded clinics is part of the statewide infertility prevention project funded by Center for Disease Control and Prevention (CDC). The overall positivity rate for family planning clients ages 15-44 is 8.3%. The SLD and STD Program maintain the results performed at SLD and the statewide reported chlamydia positive cases, respectively.//2010//

Health Status Indicators 05B: *The rate per 1,000 women aged 20 through 44 years with a reported case of chlamydia.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	12.6	6.9	36.2	33.5	33.5
Numerator	4104	2266	2722	2491	2491
Denominator	326795	329938	75171	74291	74291
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2008
2008 data not yet available

Notes - 2007
Numerator Source: NM DOH STD program
http://www.health.state.nm.us/std/pdf/ChlamydiaCasesAgeSexCounty07.pdf

Denominator Source: UNM Bureau of Business and Economic Research 2007 population estimate.

Beginning with the population estimates for 2007, the University of New Mexico Bureau of Business and Economic Research (BBER) updated its estimates of age-specific migration with

new data. This change caused a break in continuity between the 2006 and 2007 estimates. Older age groups were affected more than others. For rates calculated from BBER population estimates, any rate differences from 2006 to 2007 must be interpreted with caution, as they may be partly attributable to the change in population estimates used in the rate denominators.

Notes - 2006
Numerator Source: NM DOH STD program
http://www.health.state.nm.us/std/pdf/ChlamydiaCasesAgeSexCounty.pdf

Denominator Source: UNM Bureau of Business and Economic Research 2006 population estimate.

Not that the numbers reported for 2003 and 2004 are incorrect.

Correct figures are as follows:

2003: 2243 cases
74,039 aged 15-19 for a rate of 30.2

2004: 2564 cases
73,555 aged 15-19 for a rate of 34.9

Narrative:
/2010/In 2008, the Family Planning Program (FPP) tested 1,532 females, and 484 males ages 20-24 for chlamydia. In 2007, there were 2,491 chlamydia cases in females, and 933 cases in males.

The FPP protocol recommends chlamydia screening in pregnant women, women seeking intrauterine device insertion and any woman who is a known contact to a partner with gonorrhea, chlamydia, or non-gonococcal urethritis.

The chlamydia testing in the FPP-funded clinics is part of the statewide infertility prevention project funded by Center for Disease Control and Prevention (CDC). The overall positivity rate for family planning clients ages 15-44 is 8.3%. The SLD and STD Program maintain the results performed at SLD and the statewide reported chlamydia positive cases, respectively.//2010//

Health Status Indicators 06A: *Infants and children aged 0 through 24 years enumerated by sub-populations of age group and race. (Demographics)*

HSI #06A - Demographics (TOTAL POPULATION)

CATEGORY TOTAL POPULATION BY RACE	**Total All Races**	**White**	**Black or African American**	**American Indian or Native Alaskan**	**Asian**	**Native Hawaiian or Other Pacific Islander**	**More than one race reported**	**Other and Unknown**
Infants 0 to 1	26388	21705	694	3535	454	0	0	0
Children 1 through 4	99193	81273	2630	13664	1626	0	0	0
Children 5 through 9	121234	97318	4453	16987	2476	0	0	0
Children 10 through 14	136633	126105	5344	2481	2703	0	0	0

Children 15 through 19	167360	134168	5229	25138	2825	0	0	0
Children 20 through 24	150916	122594	5279	20486	2557	0	0	0
Children 0 through 24	701724	583163	23629	82291	12641	0	0	0

Notes - 2010

Narrative:
/2010/The University of New Mexico's Bureau of Business and Economic Research (UNM BBER) uses US Census data to create population estimates for New Mexico. UNM BBER data show that in 2007 the total population of children age 0-19 in New Mexico was 573,168, representing 28% of the total population in New Mexico.

In a 2007 press release from the US Census Bureau noted that New Mexico is one of four states, and the District of Columbia, that is "majority-minority" with 57% of its population being classified as "minority."

Also from the census bureau, New Mexico is projected to be in the top 10 fastest growing states during the period 2020 to 2025. The Census Bureau projects that by 2025, New Mexico will have more American Indian residents than California. That will place it third, behind Arizona and Oklahoma, in total population of American Indians people.

The Annie E. Casey Foundation's working paper on child improvement in well being shows that between 2000-2005, the well-being of New Mexico's children deteriorated by a factor of two (the range was +12 to -21) http://www.aecf.org/~/media/PublicationFiles/OHare%20%20Lamb%20March%202009%20Paper.pdf

Children of immigrants are the fastest growing part of the U.S. population. Most live in mixed status families. Legal and undocumented parents may be reluctant to approach publicly funded services despite their child's eligibility based on birth. Many of these children live in families with low incomes, have parents with low education level and limited English proficiency, and interact less often with their parents. These factors may be associated with poor school performance by the children. Young children of immigrants are substantially more likely to be poor and to experience food and house related hardship --56% as compared to 40% of young children of natives. Children of immigrants are more likely to have fair or poor health and to lack health insurance or a usual source of care.

Through an aggressive outreach and enrollment campaign over the past two years, the number of children eligible for and enrolled in the State Children's Health Insurance Program (SCHIP) and Medicaid are at an all-time high. As of May 2008 195,711 children (birth-age 12) are enrolled in Medicaid or SCHIP. New Mexico Medicaid provides many health services for children under a federal Medicaid policy which requires that children receive Early Period Screening, Diagnostic, and Treatment (EPSDT). This policy includes preventive health services, maintenance health services, and treatment of medical conditions. It also includes mental health or behavioral health services. Children may go to a doctor, a nurse practitioner or a physician's assistant for a well-child exam and do not need to have a specific complaint to be seen.//2010//

Health Status Indicators 06B: *Infants and children aged 0 through 24 years enumerated by sub-populations of age group and Hispanic ethnicity. (Demographics)*

HSI #06B - Demographics (TOTAL POPULATION)

CATEGORY TOTAL POPULATION BY HISPANIC ETHNICITY	**Total NOT Hispanic or Latino**	**Total Hispanic or Latino**	**Ethnicity Not Reported**
Infants 0 to 1	12293	14095	0
Children 1 through 4	46599	52594	0
Children 5 through 9	55567	65667	0
Children 10 through 14	77819	81174	0
Children 15 through 19	85769	81591	0
Children 20 through 24	76785	74131	0
Children 0 through 24	354832	369252	0

Notes - 2010

Narrative:
/2010/In 2007-2008 nearly half of Hispanics and American Indians in New Mexico went without health insurance at some point, compared with 28% of whites. Hispanics are more likely to be uninsured because they tend to work for employers that pay less and do not offer health coverage to employees. One-third of uninsured Hispanic people live in the southern part of the state, and many are children of documented Hispanic immigrants.

Fifty-six percent of American Indians and people who described themselves as being a member of more than one ethnic group (n= 136,000) reported being uninsured at some point during 2007-2008. Uninsurance among American Indians is related to cultural barriers, such as beliefs that obtaining health insurance is similar to asking for something bad to happen to themselves. In addition, many American Indians believe that they do not need health insurance because they can receive care from Indian Health Service clinics.

The Annie E. Casey Foundation's working paper on child improvement in well being shows that between 2000-2005, the well-being of New Mexico's children deteriorated by a factor of two (the range was +12 to -21) http://www.aecf.org/~/media/PublicationFiles/OHare%20%20Lamb%20March%202009%20Paper.pdf.//2010//

Health Status Indicators 07A: *Live births to women (of all ages) enumerated by maternal age and race. (Demographics)*

HSI #07A - Demographics (Total live births)

CATEGORY Total live births	**Total All Races**	**White**	**Black or African American**	**American Indian or Native Alaskan**	**Asian**	**Native Hawaiian or Other Pacific Islander**	**More than one race reported**	**Other and Unknown**
Women < 15	73	59	2	7	0	0	0	5
Women 15 through 17	1644	1325	35	240	0	4	0	40
Women 18 through 19	3191	2508	83	504	1	11	0	84
Women 20 through 34	23118	18738	472	3064	80	323	0	441

Women 35 or older	3221	2604	52	426	32	62	0	45
Women of all ages	31247	25234	644	4241	113	400	0	615

Notes - 2010

Narrative:
/2010/In 2006, there were 29,918 births to New Mexico resident mothers, translating to a birth rate of 14.9 births per 1,000 population. The state's 2006 birth rate was higher than the 2005 national rate of 14.0. From 1990 to 2006, New Mexico's teen birth rate decreased 20.6%, but increased 2.3% from 2005 to 2006. The teen birth rate was 61.7 births per 1,000 females ages 15-19. More than half (51.2%) of 2006 New Mexico births were to single mothers. The percent of births to single mothers has more than doubled in the last 22 years and increased by 9.2% from 2002 to 2006. In 2006, 61.1% of mothers received adequate or intensive prenatal care, while 38.9% received intermediate or inadequate care. This is an improvement from 2005.

New Mexico's birth rate declined from a rate of 19.1 births per 1,000 population in 1985 to 14.9 in 2006. It went up from 14.6 in 2005. The rate of teen births ages 15 to 19 years decreased 20.6% between 1990 and 2006, from 77.7 to 61.7 births per 1,000 females ages 15 to 19. There was an increase of 2.3% between 2005 and 2006. More than half (51.2%) of New Mexico births were to single mothers in 2006. The percent of single mothers in New Mexico has more than doubled in the last 22 years, and went up 9.2% between 2002 and 2006. The proportion of low birthweight infants increased from 8.5% in 2005 to 8.9% in 2006. Since 1990, the proportion of low birthweight infants has increased by 21.9% in New Mexico. First births have increased by 49.8% since 1960 -- from 25.3% in 1960 to 37.9% in 2006.

In 2006, 61.1% of mothers received adequate or intensive prenatal care, while 38.9% receive intermediate or inadequate care. Cesarean deliveries in New Mexico increased by 30.4% between 2002 and 2006. Of New Mexico's 33 counties, ten had birth rates higher than the 2006 state rate of 14.9 Lea County had the highest birth rate in the state at 19.4 The fertility rate is calculated as the number of births per 1,000 females ages 15-44. Since 2002, New Mexico's fertility rate has decreased from 69.9 (2002) to 62.7 in 2006. That same year, 98.8% of New Mexico resident births, occurred in hospitals. Medical doctors attended 69.9% and certified nurse midwives attended 28.7% of births to New Mexico residents. For the last 10 years the proportion of births occurring in New Mexico attended by medical doctors has decreased from 79.0% in 1997 to 66.2% in 2006. Correspondingly, certified nurse midwives (CNM) have attended births increasingly since 1997, with CNMs in attendance for 19.5% of births in 1997 compared to 29.9% in 2006.//2010//

Health Status Indicators 07B: *Live births to women (of all ages) enumerated by maternal age and Hispanic ethnicity. (Demographics)*

HSI #07B - Demographics (Total live births)

CATEGORY Total live births	**Total NOT Hispanic or Latino**	**Total Hispanic or Latino**	**Ethnicity Not Reported**
Women < 15	13	58	2
Women 15 through 17	487	1149	8
Women 18 through	1132	2029	30

19			
Women 20 through 34	10513	12470	135
Women 35 or older	1807	1404	10
Women of all ages	13952	17110	185

Notes - 2010

Narrative:
/2010/In 2006, Hispanic mothers had the highest fertility rate (74.4), followed by American Indian mothers at 62.5 Between 2002 and 2006, the fertility rate for Asian or Pacific Islander mothers increased, while the fertility rates for all other race/ethnicities decreased. In 2006, Hispanics in New Mexico had the highest percent of births (54.2), while in the United States, Whites had the highest percent of births (55.1) in 2005.
For 2006, the Hispanic birth rate was the highest among the state's race/ethnicity groups at 19.5 births per 1,000 Hispanic females, followed by American Indian mothers at 17.7, Asian or Pacific Islander mothers at 16.1, Black or African American mothers at 11.2, and White mothers at 9.9.

New Mexico women ages 20 to 34 years had the highest percent of births in 1990 and 2000 as well as in the period 2002 to 2006. The percent of mothers ages 40-49 increased from 1.3% in 1990 to 2.1% in 2006. In Bernalillo County, for instance, while the proportion of births to 20-24 years old mothers decreased from 33.4 to 26.8,

In 2006, Hispanic mothers had the highest fertility rate (74.4), followed by American Indian mothers at 62.5. Between 2002 and 2006, the fertility rate for Asian or Pacific Islander mothers increased, while the fertility rates for all other race/ethnicities decreased. In 2006, Hispanics in New Mexico had the highest percent of births (54.2).

Teen Births: The birth rate to 15-19 year olds in 2006 was 0.7% higher than the 2002 rate. The rate of births to 15-19 year olds decreased 20.6% between 1990 and 2006, from 77.7 births per 1,000 females ages 15-19 to 61.7. In the United States, the teen birth rate fell by nearly one third since 1990, from 59.9 to 40.5 in 2005.1 Although New Mexico's teen birth rate continues to be higher than the national rate, the difference in rates generally declined since 1990. The national birth rate for females ages 10-14 was the same in 2002 and 2005. In New Mexico, birth rates for this age group decreased 25.0% from 2002 to 2006. the proportion of births to mothers 35 years and olderincreased from 3.8 to 12.8.

Single Mothers: Between 1980 and 2006, the proportion of births to single mothers increased from 19.8% to 51.2%, an increase of 158.6%. The increase in the proportion of single mothers was highest among White females, which increased 12.6% from 2002. Compared to the United States, the 2006 proportions of births to single mothers were higher in New Mexico for ages 10-24. For ages 25-39, the proportions and rates were higher in the United States compared to New Mexico. In 2005, the most recent year for which national comparisons can be made, the proportion of births to single mothers was higher in New Mexico for every age group except mothers younger than age 15. In 2006, among the four counties with the highest proportion of births to single mothers (McKinley, Cibola, San Miguel, and Rio Arriba), the percent of births to single mothers ranged from 61.7% to 70.8%.//2010//

Health Status Indicators 08A: *Deaths of infants and children aged 0 through 24 years enumerated by age subgroup and race. (Demographics)*

HSI #08A - Demographics (Total deaths)

CATEGORY Total deaths	**Total All Races**	**White**	**Black or African American**	**American Indian or Native Alaskan**	**Asian**	**Native Hawaiian or Other Pacific Islander**	**More than one race reported**	**Other and Unknown**
Infants 0 to 1	189	140	10	34	1	0	0	4
Children 1 through 4	51	36	2	13	0	0	0	0
Children 5 through 9	23	19	0	4	0	0	0	0
Children 10 through 14	27	20	1	6	0	0	0	0
Children 15 through 19	145	107	7	26	2	0	0	3
Children 20 through 24	199	136	7	49	4	1	0	2
Children 0 through 24	634	458	27	132	7	1	0	9

Notes - 2010

Narrative:
/2010/ Infant mortality is a critical indicator of a state's wellbeing. The Healthy People 2010 goal is to reduce the infant mortality rate (IMR) to 4.5 per 1,000 live births; the neonatal mortality rate to 2.9 per 1,000 live births; and the post-neonatal mortality rate to 1.5 per 1,000 live births. The NM infant mortality rate (IMR) -- as well as the neonatal and postneonatal mortality rates -- have been at or lower than the national rate since 1980 with the exception of 1994.

In 2007, New Mexico's infant mortality rate was 604 per 100,000 live births.(6.0 per 1,000.) The child/youth death rate was 63 per 100,000 population. For Children ages 1-14, the rate was 26.6 per 100,000, and for youth ages 15-24, the rate was 106.8/100,000. In that same year, Native American New Mexicans had the highest death rate among children and youth ages 1-24 at 97 per 100,000 population, followed by African Americans at 74/100,000, and Whites had the lowest at 56/100,000. (Sources: Infant mortality data are from New Mexico Bureau Vital Records and Health Statistics NMVRHS; child mortality data are: Numerator: NMVRHS, Denominator: University of New Mexico Bureau of Business and Economic Research)

Efforts continue to assure preconception and prenatal care for women in New Mexico to ensure healthy births. During FY 09, the focus for the New Mexico Governor's Women's Health Advisory Council has been on preconception and pregnancy related issues. There is increased effort to improve a regional system of transport for premature infants to provide the services needed to assure positive outcomes after a premature birth.

The New Mexico SAFE KIDS Coalition (NMSKC) network collaborates with Safer New Mexico Now (SNMN) on the training of child car seat technicians and production of child car seat clinics. NMSKC purchases and distributes bicycle helmets statewide. SAFE KIDS representatives teach home safety workshops at the 16 annual Regional Early Care Education conferences throughout New Mexico.

New Mexico established an Office of Health Equity. The Office of Health Equity's role is to address health disparities through its Minority Health Grant. This five year grant from the US Department of Health and Human Services (DHHS) Office of Minority Health targets

health disparities in New Mexico, through key efforts such as raising awareness, mobilizing communities, increasing capacity, preventing disease, promoting health, focusing resources on targeted populations and delivering appropriate care.//2010//

Health Status Indicators 08B: *Deaths of infants and children aged 0 through 24 years enumerated by age subgroup and Hispanic ethnicity. (Demographics)*

HSI #08B - Demographics (Total deaths)

CATEGORY Total deaths	**Total NOT Hispanic or Latino**	**Total Hispanic or Latino**	**Ethnicity Not Reported**
Infants 0 to 1	75	108	6
Children 1 through 4	25	26	0
Children 5 through 9	12	11	0
Children 10 through 14	13	14	0
Children 15 through 19	58	85	2
Children 20 through 24	115	82	2
Children 0 through 24	298	326	10

Notes - 2010

Narrative:
/2010/In 2007, the infant mortality rate for Hispanic infants was 631 per 100,000 live births, and for Non-Hispanic infants it was 537 per 100,000 live births. For children/youth ages 1-24, the rates were nearly equal between the two ethnicities at 153 deaths per 100,000 Hispanic children/youth and 152 Non-Hispanic children/youth. For children ages 1-14, the rates were 25/100,000 per Hispanic and 27/100,000 per Non-Hispanic children. Among youth ages 15-24 the rates were 107/100,000 Hispanic, and 106/100,000 Non-Hispanic.

Increased emphasis on pre-conception health is a strategy to improve infant mortality. The Child Health Program, through Project LAUNCH, will provide a Child Care Health Consultant (CCHC) Coordinator to train others to perform the CCHC services of working with Child Care providers to improve the early childhood environments and the health of children in those settings. Child care environments present incredible opportunities to improve health outcomes for large numbers of children at a time, the primary goal for population based public health. Child care environments serve as ideal settings to teach children about healthy behaviors that will help them lead healthier lives. Examples include healthy eating behaviors, preventing obesity, physical activity, hand-washing, and how to prevent injuries. CCHCs also help providers and families recognize a child's targeted developmental stages and how to address possible developmental delays. The positive impact of child care health consultation with children, child care providers, and families is significant. CCHC Coordinator will work with NMSKC to assure a large number of child care providers are served.//2010//

Health Status Indicators 09A: *Infants and children aged 0 through 19 years in miscellaneous situations or enrolled in various State programs enumerated by race. (Demographics)*

HSI #09A - Demographics (Miscellaneous Data)

CATEGORY Misc Data BY RACE	**Total All Races**	**White**	**Black or African American**	**American Indian or Native Alaskan**	**Asian**	**Native Hawaiian or Other Pacific Islander**	**More than one race reported**	**Other and Unknown**	**Specific Reporting Year**
All children 0 through 19	573168	460569	18350	84165	10084	0	0	0	2007
Percent in household headed by single parent	26.7	19.0	43.1	0.0	0.0	0.0	17.7	34.8	2007
Percent in TANF (Grant) families	12.8	4.9	3.2	1.8	1.6	0.0	1.3	0.0	2008
Number enrolled in Medicaid	304277	233914	6403	55135	1699	0	7126	0	2008
Number enrolled in SCHIP	15689	12589	239	2731	106	0	24	0	2008
Number living in foster home care	2705	2218	162	298	0	0	0	27	2007
Number enrolled in food stamp program	136794	115180	3830	16142	1368	0	274	0	2008
Number enrolled in WIC	70371	62929	1378	2895	428	43	2698	0	2008
Rate (per 100,000) of juvenile crime arrests	24489.0	21732.0	758.0	1365.0	49.0	11.0	290.0	284.0	2008
Percentage of high school drop-outs (grade 9 through 12)	4.5	82.0	3.2	25.5	0.9	0.0	0.0	0.0	2008

Notes - 2010
Source: National Survey of Children's Health
http://nschdata.org/DataQuery/DataQueryResults.aspx

Percent of children in "Mother-only household with no father of any type present."

"White" is White and Hispanic, all other races are non-Hispanic.

Non-Hispanic Asian, AINA, Native Hawaiian, or Pacific Islander are grouped by NSCH as "Other" because of small samples sizes.

The number by race of TANF children is estimated based on the percent by race of head of houshold in TANF families. That number is the numerator and BBER data is the denominator.

For example: TANF reports that 90% of its head of household recipients are White. There were 25,136 TANF children. 90% of 25136 = 22622 White child recipients. BBER estimates that there

are a total of 459,634 White children ages 0-19. 22,622 is 4.9% of 459,634, therefore 5% of White children are in TANF families.

Source: Medicaid Report number AH290363 FFY08

Medicaid report combines "Asian" and "Native Hawiian/Other Pacific Islander, " and also combines "More than one race reported" and "Other and Unknown."

Source: Medicaid Report number AH290363 FFY08

Medicaid report combines "Asian" and "Native Hawiian/Other Pacific Islander, " and also combines "More than one race reported" and "Other and Unknown."

Food Stamp information is reported in percentages. Numbers are estimated based on race of head of household food stamp recipients. For example: It was reported that 84.2% of Food Stamp recipient heads of household were White. There were 136,794 individual child recipients of Food Stamps. 84.2% of 136,794 = 115,180 White child Food Stamp recipients.

For number of children enrolled in WIC: Data Note for title V MCH: These are calendar year 2008 WIC data for clients who were actually seen in 2008 in contrast to those who had a certification period that began, ended or continued in 2008 but who may not have been seen. There were an additional 10,970 who had an active certification but who were not seen; these include children who reached 5th birthday, moved or dropped out of WIC. There is an under-count of infants who were born in November and December 2008 due to unresolved issues in the programming to abstract records from the WIC system. It's estimated that the undercount was on the order of 1500 infants. This under-count has been present in all previous years as well; and will be resolved in the coming year.

Hispanic and White are combined.

HIgh School dropout numbers: (First number is percent of enrollees that dropped out, subsequent numbers should be read as "percent of dropouts that were X race")

White = 3715
Black = 143
AINA = 1149
Asian/Native Hawaiian/Other Pacific Islander = 40
Total dropouts = 4507
Total Enrollment 2006-2007 was 100,134 for grades 9-12 (2007-2008 total enrollment numbers not available at this time.

Department of Education did not report "More than one race" or "Other and Unknown"

Source: Children Youth and Families Department of New Mexico

Narrative:
/2010/Foster Care: Causal and contributing factors resulting in child maltreatment are complex. In making the determination as to when to reunify, Protective Services (PS) must consider the safety needs of the child in balance with the desire for timely reunification. Premature reunification, especially given the nature of complex family issues, can result in additional harm to a child through recurrence of maltreatment and a subsequent removal and placement into foster care. The CFSR Round 1 Standard on this measure is 76.2%. It is designed to capture the experience of all children entering foster care and recognizes the continuing need for a balance between timely reunification and assurance of child safety.

In New Mexico, entry into and exit from foster care is impacted by two entities outside of PS-- law enforcement and the courts. Law enforcement regularly places children in PS custody. More than 40% of children coming into care are able to safely exit in less than eight days. A significant proportion of PS resources are required for these children and families with urgent needs, despite their brief time in custody. The child welfare court system impacts timeliness of reunification for children remaining in custody beyond eight days. Here, delays are created by crowded court calendars, continuances, and an insufficient number of attorneys to represent the parties. Further, lack of sufficient service array, especially in non-urban settings, contributes to delays in timely family reunification. Juvenile Crime: With the adoption of the Cambiar New Mexico model, Juvenile Justice Services (JJS) shifts its focus from confinement and punishment to rehabilitation and regionalization. They will continue to hold young people accountable while we provide for their rehabilitation and prepare them for healthy adulthood. They will protect them from harm, and will continue to provide for public safety. Their strategies include:

- Greater collaboration with communities to identify and promote more intensive services to meet unique probation or parole demands in each county for youth and their families.

- Continued implementation of comprehensive system to ensure needs of clients paroling into the community are met, including regular development and utilization of discharge plans.

- Increased emphasis on transitional services for clients in communities, including services such as housing, education, employment, behavioral health, etc.

- Implementation of more intensive behavioral health services and greater accessibility to substance abuse counseling.

http://www.cyfd.org/pdf/FY09quarterly_Q3_050609.pdf//2010//

Health Status Indicators 09B: *Infants and children aged 0 through 19 years in miscellaneous situations or enrolled in various State programs enumerated by Hispanic ethnicity. (Demographics)*

HSI #09B - Demographics (Miscellaneous Data)

CATEGORY Miscellaneous Data BY HISPANIC ETHNICITY	**Total NOT Hispanic or Latino**	**Total Hispanic or Latino**	**Ethnicity Not Reported**	**Specific Reporting Year**
All children 0 through 19	278047	295121	0	2007
Percent in household headed by single parent	27.7	22.8	0.0	2007
Percent in TANF (Grant) families	2.6	5.9	0.0	2008
Number enrolled in Medicaid	120603	176548	7126	2008
Number enrolled in SCHIP	6648	9017	24	2008
Number living in foster home care	1055	1569	81	2007
Number enrolled in food stamp program	83033	53760	0	2008
Number enrolled in WIC	14831	55400	140	2008
Rate (per 100,000) of juvenile crime arrests	8694.0	15160.0	303.0	2008
Percentage of high school drop-	28.5	71.4	0.0	2008

outs (grade 9 through 12)				

Notes - 2010
For number of children enrolled in WIC: Data Note for title V MCH: These are calendar year 2008 WIC data for clients who were actually seen in 2008 in contrast to those who had a certification period that began, ended or continued in 2008 but who may not have been seen. There were an additional 10,970 who had an active certification but who were not seen; these include children who reached 5th birthday, moved or dropped out of WIC. There is an under-count of infants who were born in November and December 2008 due to unresolved issues in the programming to abstract records from the WIC system. It's estimated that the undercount was on the order of 1500 infants. This under-count has been present in all previous years as well; and will be resolved in the coming year.

28.5 percent of dropouts were not Hispanic, 71.4 percent of dropouts were Hispanic.

Narrative:
/2010/Drop outs: Over the past three years, New Mexico has undertaken and implemented redesign of its high school education system. Although the results of the system redesign have yet to be fully realized and reported, some have begun to show immediate effect. For example, after the 2007 Dual Credit Rule and Master Agreement were established, students became aware of and enrolled in dual credit classes in record numbers. Participation in online learning or distance education has also shown record enrollment with the establishment of the statewide 'cyber academy' or IDEAL-NM (Innovative Digital Education and Learning -- New Mexico). Data systems have been established and refined to annually produce continuing enrollment of ninth grade cohort groups. Career and technical education has a renewed focus on New Mexico's seven career clusters. Staying in high school and earning a diploma has become a statewide focus.

To help students stay in school or become re-engaged, New Mexico invests resources in several intervention programs. Some examples are: the Governor's Truancy/Dropout Prevention Program which is based on best-practice models and focuses on schools, children and families (including school staffs, truancy officers, juvenile justice, courts, counselors); the Family and Youth Resource Program which focuses on the non-academic issues facing families and students that stand in the way of student success; and coordinated after-school enrichment and school-based health care programs (including School-Based Health Centers) which provide physical and mental health to students.

New Mexico students drop out for a variety of reasons and the data do not always capture the underlying causes. The top three reasons reported include: 1) did not re-enroll (19.6%); 2) invalid transfer (16.4%); and 3) intends to take GED (14.2%). What is not reflected in the reported reasons are the social, health and economic stresses that can affect dropout rates. Students may leave school to help support their families. Poverty is an underlying stress factor for students. For example, without adequate health care and nutrition, students may be absent more often from school due to poor health. Sometimes, family economics may require an older sibling to care for younger siblings who are at home, thereby affecting the student's regular school attendance. Some other factors that can influence dropout rates are: experimentation with drugs, teen pregnancy, chronic diseases, and being bullied.//2010//

Health Status Indicators 10: *Geographic living area for all children aged 0 through 19 years.*

HSI #10 - Demographics (Geographic Living Area)

Geographic Living Area	Total
Living in metropolitan areas	287332
Living in urban areas	167804
Living in rural areas	358298
Living in frontier areas	37296
Total - all children 0 through 19	563398

Notes - 2010
Approximately 51% of children 0-19 live in metropolitan areas in New Mexico.

Frontier includes "Sub-Frontier"

Narrative:
/2010/Fourteen of New Mexico's 33 counties are considered "Frontier" or "Sub-Frontier." Eighteen counties are "Rural" and one is "Urban." Projections based on the 2000 census show county populations of children ages 0-19 ranging from 131 in Harding county to 167,804 in Bernalillo county.

Eight counties have a population density per square mile of 20 or above. The remaining 25 have population densities of less than 14. The range is .4 persons per square mile in Harding County to 477.4 persons per square mile in Bernalillo county.

Geographic distance has long been recognized as a barrier to health care access for New Mexicans. For 2010, the State has part of its strategic plan two objectives that seek to address these issues. The first is to "Improve recruitment, retention and training of health care providers in rural and underserved areas." The strategies to achieve this objective are:
The following strategies have been drafted to address this problem:

1. Continue to standardize and streamline health professional licensing processes in New Mexico, including reciprocity where appropriate.
2. Consider strategies to improve healthcare provider compensation rates in New Mexico to remain competitive with rising compensation rates in surrounding states.
3. Expand health professional education and training programs in the state's universities and colleges to produce an increased "home grown," in-state health workforce.
4. Continue to develop incentives to recruit and retain health professionals in all areas of the state.
5. Research incentives to educational systems to bring health professional education programs to rural areas of the state.
6. Continue to explore increased opportunities for training and rural residency sites in the Department's Public Health Offices for health professionals.
7. Continue to assess rural health needs and continue to offer incentives to health professionals to serve in rural and underserved communities.
8. Work to expand WICHE scholarships, loan forgiveness and debt forgiveness programs.

The second objective is to "Increase use of technologies to improve health outcomes." Strategies to achieve this include:

1. Assess the computer and services needs of all DOH programs.
2. Build infrastructure at local Public Health Offices to support advancing technology (electronic medical records, telehealth, video conferences).
3. Expand use of telehealth technology to all New Mexico hospitals and primary care centers.
4. Assist the Telehealth Commission by evaluating and integrating individual agency

telehealth efforts.
5. Maintain inventory of current telehealth services, sites and resources.
6. Expand network of telehealth services in primary care facilities, school based health centers, juvenile justice facilities and juvenile probation and parole offices.//2010//

Health Status Indicators 11: *Percent of the State population at various levels of the federal poverty level.*

HSI #11 - Demographics (Poverty Levels)

Poverty Levels	Total
Total Population	2010787.0
Percent Below: 50% of poverty	7.3
100% of poverty	23.0
200% of poverty	38.7

Notes - 2010
Percent report of below 100% poverty is actually below 125% of poverty.

Narrative:
/2010/In many parts of New Mexico, it costs more than twice the FPL for families to provide the basics for their children. Over the years, wages have not kept up with inflation, and hence, paychecks have not stretched as far to pay for the rising cost of necessities. Families that were struggling before the current economic slump are likely to feel the pressure on their budgets even more acutely now.

The New Mexico Voices for Children Kids 2008 report highlights the discrepancies between those that are considered living under the poverty level and those that are technically above it but still struggling to get by. The percentage of children that are considered to be "living below poverty" may not accurately reflect just how many children live in families that are struggling to meet their basic needs. While the official poverty measure, commonly referred to as the federal poverty level (FPL), is supposed to indicate how much it costs a family to live at a bare minimum, by many accounts the actual costs are roughly twice the FPL. People who fall below the official poverty level are deemed "poor." This leaves open the assumption that anyone making more than the FPL are "not poor."

Whether a family makes $1, $1,000, or even $10,000 above the FPL, that family is likely struggling to make ends meet. The poverty measure was created based on a 1950's survey that found families were spending one-third of their budget on food. Today, however, food constitutes about one-seventh of a family's budget, making the poverty measure an inadequate one for assessing a sufficient standard of living for families. Moreover, child care is a major expense for working families nowadays, as well as housing, transportation, or health care -- all of which families need to survive and is not calculated in the measure.

Problematically, the poverty measure does not take geographical location or family configurations into consideration, which means that the FPL is the same for a family in the inner-city where costs are high and for a family living in a rural area with relatively lower costs. All of these factors make it very difficult for families to provide the basic necessities for their children, let alone improve their situation, even when they live at 200 percent -- or double -- the official FPL.

The Basic Family Budget gives a more realistic measure of how much it costs to support a family. Seven expenditures are included in this budget: housing, food, child care, transportation, health care, other necessities, and taxes. Basic Family Budgets are calculated for communities all across the U.S. for six family types--one- and two-parent families with one, two, and three children. In New Mexico, budgets are available for Albuquerque, Las Cruces, Santa Fe, and Farmington. Source: http://www.nmvoices.org/attachments/nm_kc_08_essay.pdf//2010//

Health Status Indicators 12: *Percent of the State population aged 0 through 19 years at various levels of the federal poverty level.*

HSI #12 - Demographics (Poverty Levels)

Poverty Levels	Total
Children 0 through 19 years old	573168.0
Percent Below: 50% of poverty	10.7
100% of poverty	27.7
200% of poverty	23.4

Notes - 2010

Narrative:
/2010/In many parts of New Mexico, it costs more than twice the FPL for families to provide the basics for their children. Over the years, wages have not kept up with inflation, and hence, paychecks have not stretched as far to pay for the rising cost of necessities. Families that were struggling before the current economic slump are likely to feel the pressure on their budgets even more acutely now.

The New Mexico Voices for Children Kids 2008 report highlights the discrepancies between those that are considered living under the poverty level and those that are technically above it but still struggling to get by. The percentage of children that are considered to be "living below poverty" may not accurately reflect just how many children live in families that are struggling to meet their basic needs. While the official poverty measure, commonly referred to as the federal poverty level (FPL), is supposed to indicate how much it costs a family to live at a bare minimum, by many accounts the actual costs are roughly twice the FPL. People who fall below the official poverty level are deemed "poor." This leaves open the assumption that anyone making more than the FPL are "not poor."

Whether a family makes $1, $1,000, or even $10,000 above the FPL, that family is likely struggling to make ends meet. The poverty measure was created based on a 1950's survey that found families were spending one-third of their budget on food. Today, however, food constitutes about one-seventh of a family's budget, making the poverty measure an inadequate one for assessing a sufficient standard of living for families. Moreover, child care is a major expense for working families nowadays, as well as housing, transportation, or health care -- all of which families need to survive and is not calculated in the measure.

Problematically, the poverty measure does not take geographical location or family configurations into consideration, which means that the FPL is the same for a family in the inner-city where costs are high and for a family living in a rural area with relatively lower costs. All of these factors make it very difficult for families to provide the basic necessities for their children, let alone improve their situation, even when they live at 200 percent -- or double -- the official FPL.

The Basic Family Budget gives a more realistic measure of how much it costs to support a family. Seven expenditures are included in this budget: housing, food, child care, transportation, health care, other necessities, and taxes. Basic Family Budgets are calculated for communities all across the U.S. for six family types--one- and two-parent families with one, two, and three children. In New Mexico, budgets are available for Albuquerque, Las Cruces, Santa Fe, and Farmington.

Source: http://www.nmvoices.org/attachments/nm_kids_count_2008.pdf//2010//

F. Other Program Activities

Early Childhood Comprehensive Systems Grant: New Mexico Title V Program is developing a comprehensive State-level multi-agency service system, which reaches to the community-level and will support families in fostering the healthy development of their children. There is a crucial need for early childhood systems alignment and integration in New Mexico. New Mexico service systems can better serve families by removing system barriers through cross-agency early childhood systems development planning. The Early Childhood Comprehensive Systems (ECCS) grant is an important opportunity to supplement this systems development work of the State Title V Program.

New Mexico's ECCS planning project has, after two years of work, resulted in a Comprehensive Plan for Early Childhood that includes the following twelve required content areas including: an environmental scan, a vision and mission statement, five priority areas of focus, goals and objectives with timeframes for completion, a set of indicators to track early childhood outcomes, documentation of the strategic planning process with stakeholders, identification of best practice, evidence-based models, identification of key partners, linkages to other State initiatives, evidence that the planning process is positioned to maximize the greatest policy impact, a sustainability plan for the follow up implementation phase, and strategies to strengthen data collection and make system improvements. The Children's Cabinet has supported this work and it has provided input across 12 state agencies to achieve identified policy improvements for infants, toddlers, young children and their families. During the process, important relationships were formed across state agencies, and between state agencies, the provider population and families. The basic infrastructure now set up will support development and alignment activities as the objectives of the project are implemented. WIC/MCH data sharing initiative: The Title V Director and the MCH Epidemiologist are commencing discussions with the National WIC Director to facilitate the sharing of WIC data in MCH settings. The National WIC Director has been invited to an Atlanta meeting to speak to the MCH data community about WIC regulations, confidentiality and opportunities for data sharing.

/2008/The Title V Director was involved with several initiatives this year, including the Interagency Nutrition Council which wrote a grant application for Obesity funding to place a pilot program for program alignment in the Las Cruces area. The grant proposes to increase access, opportunities, and resources to nutrition and physical fitness activities to empower New Mexican children, youth, and families to make the lifestyle behavior changes necessary to achieve healthier weights and prevent obesity. Special attention will focus on increasing access, opportunities, and resources for low-income children in schools, at home, and within the healthcare and food systems environments. She served on the Enterprise Eligibility System Interagency Team to implement a data system for ten state departments to improve access to families in New Mexico. The Title V Director and the Senior Epidemiologist worked with the Rocky Mountain Health Education Consortium to collaborate on a grant application for Maternal Depression Screening.

She worked with Title X on the Governor's Priority of Teen Pregnancy Prevention on a weekly basis throughout the year, preparing briefings for the Secretary of Health and the Governor on strategic activities. Title V chaired the Public Health Nutritionist Survey conducted by the Association of State and Territorial Nutrition Directors in 2007. Title V presented the newly developed New Mexico Preconception Index in the Western Region MCH Leadership Institute in Portland Oregon as formal comment on the presentation for Origins of Health and Disease. Title V served on the LEND Advisory Committee. Title V staffed the ECCS Turn the Curve Conference as well as the Family Leadership Action Network Conference this year.//2008//

/2010/ The ECCS grant initiative successfully completed a five-year project and celebrated the many successes of the initiative in May, 2009. The year ended with a Family Leadership Conference attended by over 200 families and an Early Childhood Forum/Turn the Curve Conference jointly sponsored by the W.K. Kellogg Foundation and the Early Childhood Action Network (ECAN). The Forum was attended by over 450 early childhood practitioners, providers, and advocates representing a multitude of organizations and agencies from all parts of the state. Title V staff were instrumental in the planning of both conferences and assisted in the work of offering them to larger than expected groups of providers and consumers of early childhood services. Additionally, Title V staff, in collaboration with a grant writer from Children, Youth & Families Department, successfully competed for one of six Project LAUNCH (Linking Actions for Unmet Needs in Children's Health) grants offered by the Substance Abuse and Mental Health Services Administration (SAMHSA). Project LAUNCH encourages a public health approach to address the health and wellness of young children and their families. The Project LAUNCH initiative produced updated State and Santa Fe County Environmental Scans of early childhood services. The ECCS and Project LAUNCH initiatives are working together to revise the Early Childhood Strategic Plan, which will be approved by the Cabinet Secretaries of Health, Human Services, Public Education, and Children, Youth and Families. //2010//

/2010/ The Medical Director for CMS, the Title V Program for Children and Youth with Special Health Care Needs, serves on the Multi-Agency Team Council on Young Child Wellness, which is part of the ECCS project. The Title V Special Needs Director and the CMS Medical Director served on the LEND Advisory Committee. //2010//

G. Technical Assistance

Requested leadership training for Title V MCH program's management team, see form 15.

/2008/Technical assistance is requested to meet performance measures related to Children with Special Heath Care Needs originating with birth defects. We wish to improve state system capacity indicators by providing training on the use of ICD9 Procedure codes, combined with ICD9 diagnostic codes for the purposes of birth defects surveillance. We receive up to 9 ICD9 discharge diagnoses, and up to 6 ICD9 procedure codes from birthing hospitals. We would like assistance in using this information to determine the best birth defect diagnosis, and to determine which infants/children we need further information on.//2008//

/2009/New Mexico has no technical assistance requests for 2009.//2009//

V. Budget Narrative

A. Expenditures

Significant Year to Year Expenditure Variations:

In the fiscal year 2005, the expenditures for services for children and adolescents as well as children with special health care needs are higher than the required percentages, similar to other states. The amount expended toward services to children and adolescents represents approximately 46 percent of the total MCH federal budget. The amount allocated toward children with special health care needs represents 36 percent of the federal budget. Overall, the amount allocated toward children and adolescents, including the state funding equals 45 percent of the entire budget, and for children with special health care needs the percentage of the entire budget is 41 percent. The amount spent on mothers represents 12 percent of the entire budget. Fifteen percent of the total was spent on women out of the federal budget. ***/2010/Current expenditure was noted at 33 percent of the federal budget; 18 percent was expended on women, specifically mothers out of the federal budget and 47 percent was expended on children and adolescents, and less than 2 percent was expended on administrative services.//2010//*** There is only one significant variation in expenditures from FY2004 to FY 2005. The grant state match amount has been met and there were significantly more state funds expended on MCH services for safety net services such as High Risk Prenatal Care Fund, Maternal Health, and Children with Special Health Care Needs during FY2005 as compared to FY2004. It is evident through analysis of expenditures, that the grant continues to be spent more and more on direct services due to several factors. First, there is a great influx of undocumented immigrants coming to the State. Hospital costs continue to increase. The CSHCN Program has made a concerted effort to transition the highest cost patients to the New Mexico Medical Insurance Pool (MIP). An analysis of state and federal support since 2003 indicates that there is a steady decline in both state and federal support for the Program. It was necessary to hold expenses by $198,776.78 from 2003 to 2004 and then to reduce spending by $161,902.17 from 2004 to 2005. In 2004 there was a reduction of $28,695.00 in federal funding and in 2005 there was an additional federal reduction of $81,694.00. The State was informed in the Spring that the 2006 grant would be cut by $250,618.00. The State also decreased its support for the program from 2003 to 2004 by $170,081.78 and from 2004 to 2005 by $80,208.17. So the state has not offset the federal reduction in funding, thus direct services are depleting funds for some infrastructure and population based services. Due to federal budget cuts, the federal grant was reduced by $80,208.17 from 2004 to 2005. The same year, the State had to decrease the amount it spent on critical MCH services services absorbing an overall decrease of $161,902.17. Although the Bureau applied for expansion of state funding for children with special health care needs, that request was denied. Costs are still escalating for serving children with special health care needs. The flat budget for the CMS Program over the last few years resulted in increased pressure from the hospitals to increase per diem rates for hospitalized children and youth. The Healthier Kids Fund Program has been level funded since 1999 resulting in extremely limited enrollment of approximately 1500 children. The cost to serve children under this program was less than $300.00 per child per year. The administration has also indicated sufficient funding the cover salaries and benefits next year. Unfortunately, due to creation of an excess of positions in state government many position of the public health division were deleted and must now be recreated on a position to position basis. This happened to 6 positions in Family Health Bureau, although some were required and covered by federal grants, such as WIC. ***/2010/The Title V Block Grant awarded in 2009 was decreased approximately $88,000 all program budgets receiving funding through the block grant were had to adjust accordingly.//2010//***

The Bureau continues to try to proactively address factors impacting birth outcomes such as obesity, preconception, prenatal care utilization, alcohol, substance abuse, tobacco, mental health, unintended pregnancy, and eliminating disparities between documented and undocumented pregnant women in access to services. While evidence-based interventions are increasingly requested, there are few resources to evaluate the impact of programs.***/2010/The***

status remains status quo at this time however, after a Legislative Finance Committee audit, the Bureau was encouraged to pilot a Family Nurse Partnership program to address many of these issues. It was recommended that funding for such a project should be requested next legislative session.//2010

The Family Planning Program received a continued federal grant in FY2005 to support reproductive health services in the state./2010/The Family Planning Program also wrote to and received the Male Involvement grant which funded three positions to work with this population in three different sites.//2010 The WIC Program received funding to expand the EBT project statewide. The CSHCN program applied for a comprehensive grant but was not awarded the grant. The need for safety net programs has not diminished in the face of Medicaid budget deficits and increased immigration. The High Risk Prenatal Care fund which uses state funds to serve undocumented immigrants has far outstripped current resources. The Bureau is applying for state expansion funds in this area, but due to many budget challenges, the state may not prioritize this need.

/2008/ The report submitted is a preliminary report based on a lack of the final financial report from the new financial system implemented across New Mexico this year. A significant journal entry related to salaries will impact the final financial report. Changes to reflect that report will be submitted by the appropriate date. In the fiscal year 2006, the expenditures for services for children and adolescents as well as children with special health care needs are higher than the required percentages, similar to other states. The amount expended toward services to children and adolescents represents approximately 50 percent of the total MCH federal budget. The amount allocated toward children with special health care needs represents 35 percent of the federal budget. Thirteen percent of the total was spent on women out of the federal budget. Overall, the amount allocated toward children and adolescents, including the state funding equals 48 percent of the entire budget, and for children with special health care needs the percentage of the entire budget is 40 percent. The amount spent on women represents 11 percent of the entire budget./2010/As noted the financial report is a preliminary report based on the final financial state report. As well as validation from the new financial system currently in place as of July 2007.//2010//

There is only one significant variation in expenditures from FY2005 to FY 2006. The grant state match amount has been met and the final expenditures will reflect that significantly more state funds were expended on MCH services for safety net services such as High Risk Prenatal Care Fund, Maternal Health, and Children with Special Health Care Needs during FY2006 as compared to FY2005. It is evident through analysis of expenditures, that the grant continues to be spent more and more on direct services due to several factors. First, there is a great influx of undocumented immigrants coming to the State. Hospital costs continue to increase. The CSHCN Program has succeeded in transitioning the highest cost patients to the New Mexico Medical Insurance Pool (NMMIP). An analysis of state and federal support since 2003 indicates that there is a steady decline in federal support for the Program. The State was informed in the Spring that the 2006 grant would be cut by $250,618.00. Reductions in expenses were implemented. Reports indicate that the demand for direct services are depleting funds for some infrastructure and population-based services. Costs are still escalating for serving children with special health care needs. The flat budget for the CMS Program over the last few years resulted in increased pressure from the hospitals to increase per diem rates for hospitalized children and youth. The UNMH has required the State to pay a 5% salary increase for providers in Neurology specialty clinic contracts, a trend that may soon be seen in other specialty clinics. The Healthier Kids Fund Program has been level funded since 1999 resulting in extremely limited enrollment. The cost to serve children under this program is less than $300.00 per child per year. In 2006, due to creation of an excess of positions in state government many position of the public health division were deleted and had be recreated on a position to position basis. Six positions were affected and only restored by April of 2007, although some were required and covered by federal grants, such as WIC.

The Bureau continues to try to proactively address factors impacting birth outcomes such as unintended pregnancy, obesity, preconception, prenatal care utilization, alcohol, substance abuse, tobacco, mental health, and eliminating disparities between documented and undocumented pregnant women in access to services. While evidence-based interventions are increasingly requested, there are few resources to evaluate the impact of programs.

The Family Planning Program received a continued federal grant in FY2006 to support reproductive health services in the state. The WIC Program received $2 million in funding to continue expansion of the EBT rollout statewide. During the FY07 legislative session, Governor Richardson issued his Children with Disabilities Agenda for FY '08. For Children's Medical Services (CMS) Children and Youth with Special Health Care Needs Program (CYSHCN), Governor Richardson proposed an increase in multidisciplinary pediatric outreach clinics in outlying areas. Governor Richardson became aware that there were not enough clinics to meet the expressed need for pediatric specialty services for children in rural areas. He proposed a 1 million dollar expansion for CMS. The Legislature appropriated $500,000.00 for a combination of CMS issues. $100,000 was given for the deaf and hard of hearing community, $100,000 went to the blind and visually impaired community and $300,000 was given to CMS for orthopedic patients and will be used for addressing an unmet need for outpatient orthopedic services for existing CMS clients. The need for safety net programs has not diminished in the face of Medicaid budget deficits and increased immigration. The High Risk Prenatal Care fund which uses state funds to serve undocumented immigrants has far outstripped current resources. //2008//

/2009/ During the 2008 legislative session Governor Richardson introduced his proposal to Achieve Universal Health Coverage. As noted the goal was to achieve universal health coverage, improve access, and quality of health care, and contain costs while preserving roles for government, employers, private vendors, providers, and individuals and families. The proposal of Insurance reform included but was not limited to: making coverage more affordable and accessible would require 85% of premiums collected to be spent on direct services. It proposed to guarantee individual coverage without exclusion of pre-existing conditions. Hold down cost increases for small employers by changing from 20% to 10% the amount premiums can be increased above the average rate because of health status or experience (phased in over five years and retaining rating by age and geography). Analyze and recommend methods to increase New Mexico practitioners/providers/facilities acceptance of Medicaid and other public sources of payment for health care. Allow HIS and the tribal 638 providers to be part of a carrier's provide network, serving only Native Americans. Protect the retiree trust fund and allow partners of retirees to be covered. Require unduplicated but common data reporting from all insurance companies for all products and from employers, practitioners and health care facilities. Provide broker/ agents opportunities to offer state funded public products, with limited immunity from liability if trained and certified to offer such products. Impose a moratorium on additional insurance benefit mandates. Require periodic effectiveness and cost analyses of existing and proposed mandated benefits. Along those noted it would include Coverage Mechanisms and Participation, which would assure health coverage to everyone. The Health coverage authority designed to reduce Bureaucracy; Create a single point of accountability. Electronic Health transactions and information to control costs and increase quality was also proposed. Unfortunately, soon after the proposal, Governor Richardson announced his candidacy for president and the efforts needed to push this forward did not materialize.//2009//***//2010/the proposal to Achieve Universal Health Coverage was tabled, however the introduction of a new electronic health record (HER) passed. New Mexico implemented the Billing Electronic Health Record (BEHR) which is now statewide, however not all programs can utilize the services since the system was not built to accommodate services such as case management. DOH is currently working on the ability to obtain reports from the system.//2010//***

B. Budget

The Federal support received from the MCH Block grant complements the State's total efforts to optimize services to the MCH population. In the 2007 federal grant budget, the amounts allocated to services for children and adolescents as well as children with special health care needs are higher than the required percentages and slightly higher than FY2006. The amount allocated toward services to children and adolescents represents approximately 48% of the total MCH federal budget. The amount allocated toward children with special health care needs represents 39 percent of the federal budget. The remaining amount of $1,257,225 allocated for women, represents only 12 percent of the federal budget. Only 1% of the federal budget is expended on administration. Overall, the amount allocated toward Children and Adolescents, including the state funding equals 48 percent of the entire budget, and for children with special health care needs the percentage of the entire budget is 35 percent. The amount spent on mothers represents 15 percent of the entire budget. This, however, is changing currently as all resources previously spent for prenatal care media campaigns have been shifted to the High Risk Prenatal Care Fund. In addition, other resources are being sought to fill this need. The year has been spent analyzing current budgets across Title V programs. A review of the final FY2003 budget as compared to the initial budget for SFY2006 (state year), indicates that the Family Health Bureau has sustained an overall $360,678.00 cut in state MCH funding over time. The Public Health Division has increased the FY2007 budget to provide a flat budget for the entire program from 2006 to 2007 at 10,417,782. This reflects the $250,618 reduction sustained in 2006 and an increase in state funding of $393,800.00. With the initial low budgeting of the program by the Public Health Division and the budget adjustments later, during the year to meet costs of safety net operations, seldom can the Title V Program operate within 10 percent of the original state year budget as required by the software of MCHB, as noted in the report.

The summary budgets are an aggregation of all of the Organization Codes (programmatic financial accounts) that relate to Maternal and Child Health. These Organization Codes are program specific: e.g., Maternal Health, Title V /2005/ Adolescent Pregnancy Prevention/Family Planning, Child Health, Adolescent Health/Youth Development, Children's Medical Services, etc. Each Organization Code is allocated funding showing the federal/state distribution.***/2010/ The State of New Mexico converted over to a new financial system known as SHARE. This system now tracks budgets via a Department code, fund codes and project ID's, depending on the funding source. We are just entering the second year of this system and have worked through many of the issues that plagued the system upon it's introduction. //2010//*** The state match amount is considerably greater than the required three state dollars to four federal dollars and is also greater than the 1989 Maintenance of Effort amount of $3,087,900.

The state match is almost entirely from appropriations from the state general funds; a very small amount is from third party payments. The federal percent of the budget is based upon the level of funding in New Mexico's share of the MCH Block Grant for FFY 2007. Budget expansions have not yet been submitted for 2008, although the Title V Director has been the leader of the MCH initiative budget request, a priority of the Public Health Division. Budget allocations are official for 2007 as submitted in this grant application. /2009/ Budget proposals are currently being reviewed; two requests submitted by the Family Health Bureau are in the top five of possibilities. One of the requests is to fund reducing the Prevalence of Low Birth weight/Birth defects. New Mexico has high rates of birth defects, low levels of early prenatal care and oral health care. Preconception health care: Birth defects and low birth weight are both associated with short and long term expensive medical costs and reduced lifelong productivity. Within public health clinics clients receive very limited screening and education to promote healthy behaviors related to pre-pregnancy health risks of family Violence, Alcohol, Substance abuse and Tobacco (VAST). Prenatal care has been shown to prevent poor birth outcomes. Oral Health care before and during pregnancy is increasingly seen as a way to prevent premature birth and low birth weight. The other request that is in the top five is preventing teen pregnancy, suicide and gambling. Suicide, pregnancy and gambling are three major health issues among teens in New Mexico. Suicide among youth aged 15-24 is a major health crisis in New Mexico. In 2004, the national

youth suicide rate was 10.1 per 100,000 while New Mexico's rate was an alarming 25.5 per 100,000. Nationally, suicide is the third leading cause of death for 15-25 year olds. In New Mexico it is the second leading cause of death.//2009//

/2010/The budget request for allocations towards the MCH initiative did not pass, therefore the MCH initiative was left flat funded for the majority of 2009 with the exception of budget cuts beginning in November of 2009. Due to the economy any monies from our general fund that was not being paid out or encumbered was to disencumbered back to the Department to cover existing expenses. Contracts were cut by 1.5%. And vacant positions were placed on a freeze. By initiating these measures the Department ensured furloughs did not occur.//2010//

A home visiting program appropriated to the Children Youth and Families Department $500,000.00. They subsequently gave to funds to the DOH to carry out a three tiered approach to home visiting based upon a welcome baby visit to all mothers, and secondary nurse and social worker visits to families needed additional services. Families FIRST set up the program during this year. Santa Fe County also had its own state funded home visiting program serving only that county; however, those costs have now been absorbed by the DOH for continuance of the program. The program expanded home visiting in two pilot sites, Santa Fe and Las Cruces. Unfortunately, that funding was ceased for next year and $1.5 million was appropriated to a local agency to set up a nurse family home visiting model. DOH will try to collaborate with that program in its expansion to three counties.

/2010/The Legislative Finance Committee (LFC) performed a cross agency audit of all early childhood programs to determine efficiency and duplicative efforts for services. The LFC determined the DOH was performing in the best interests of early childhood as noted by the data provided by the Department. LFC recommended the DOH consider implementing a pilot project of the Family Nurse Partnership and requesting legislative financing for such and endeavor. This would assist with many of the early childhood indicators.//2010//

The Direct health services are targeted to those with low incomes or with limited access to services who are uninsured or underinsured. The administrative component, paid totally out of state funds is comprised of the Family Health Bureau Chief's budget and includes fiscal, program, and personnel management, systems maintenance, strategic planning, and advocacy.

The budget meets the target percentages for Preventive and Primary Care for Children , Children with Special Health Care Needs, and Administration (is totally paid out of general fund).
The Department of Health's accounting system contains defined accounting codes for revenues and expenditures in each specific component of the maternal and child health program. Budgets are detailed by these accounting codes and expenditures charged to each specific component. The Department maintains financial accounting records and has a fiscal management system, both of which ensure a clear audit trail.

/2008/ The Federal support received from the MCH Block grant complements the State's total efforts to optimize services to the MCH population. In the 2008 federal grant budget, the amounts allocated to services for children and adolescents as well as children with special health care needs are higher than the required percentages. The amount allocated toward services to children and adolescents represents approximately 50% of the total MCH federal budget. The amount allocated toward children with special health care needs represents 35 percent of the federal budget. The remaining amount of $2,073,389 allocated for women, represents only 13 percent of the federal Title V budget. Less than 1% of the federal budget, $88,212.00 is expended on administration. Overall, the amount allocated toward children and adolescents, including the state funding equals 48 percent of the entire budget, and for children with special health care needs the percentage of the entire budget is 40 percent. The amount spent on mothers represents 11 percent of the entire budget. A review of the final FY2003 budget as compared to the initial budget for SFY2008 (state year), indicates that the Family Health Bureau

has sustained an overall $257,987.00 cut in state MCH funding over time. The Public Health Division has maintained the FY2008 budget to provide a flat budget for the entire program from 2007 to 2008 at 10,510,428. This still reflects the $250,618 federal budget reduction sustained in 2006. The administration has indicated sufficient funding the cover increased salaries and benefits next year for state employees.

/2010/The block grant award received in 2009 decreased by approximately $88,000. Program budgets were adjusted for the cut accordingly. Services were affected either by the cut to services, the number of people served or the number of staff available to provide the services.//2010//

The summary budgets are an aggregation of all of the Project Identification Codes (programmatic financial accounts) that relate to Maternal and Child Health. These Project Identification Codes are program specific: e.g., Maternal Health, Title V, Adolescent Pregnancy Prevention/Family Planning, Child Health, Adolescent Health/Youth Development, Children's Medical Services, etc. Each Project I.D. is allocated funding showing the federal/state distribution. The state match amount is considerably greater than the required three state dollars to four federal dollars and is also greater than the 1989 Maintenance of Effort amount of $3,087,900.

The state match is almost entirely from appropriations from the state general funds; a very small amount is from third party payments. The federal percent of the budget is based upon the level of funding in New Mexico's share of the MCH Block Grant for FFY 2008. Budget expansions have not yet been submitted for 2009, although the Title V Director has been the leader of the Prenatal/Preconception initiative budget request, a priority of the Public Health Division. Budget allocations are preliminary for 2008 as submitted in this grant application. /2009/ The budget allocations remained the same for 2009. //2009//***/2010/ Due to the economic status, budget allocations decreased this year for services not associated to the federal match to the Block Grant.//2010//***

The Direct health services are targeted to those with low incomes or with limited access to services who are uninsured or underinsured. The administrative component, paid totally out of state funds is comprised of the Family Health Bureau Chief's budget and includes fiscal, program, and personnel management, systems maintenance, strategic planning, and advocacy.

The budget meets the target percentages for Preventive and Primary Care for Children , Children with Special Health Care Needs, and Administration (is totally paid out of general fund). The Department of Health's accounting system contains defined accounting codes for revenues and expenditures in each specific component of the maternal and child health program. Budgets are detailed by these accounting codes and expenditures charged to each specific component. The Department maintains financial accounting records and has a fiscal management system, both of which ensure a clear audit trail. //2008//

VI. Reporting Forms-General Information
Please refer to Forms 2-21, completed by the state as part of its online application.

VII. Performance and Outcome Measure Detail Sheets
For the National Performance Measures, detail sheets are provided as a part of the Guidance. States create one detail sheet for each state performance measure; to view these detail sheets please refer to Form 16 in the Forms section of the online application.

VIII. Glossary
A standard glossary is provided as a part of the Guidance; if the state has also provided a state-specific glossary, it will appear as an attachment to this section.

IX. Technical Note
Please refer to Section IX of the Guidance.

X. Appendices and State Supporting documents
A. Needs Assessment
Please refer to Section II attachments, if provided.

B. All Reporting Forms
Please refer to Forms 2-21 completed as part of the online application.

C. Organizational Charts and All Other State Supporting Documents
Please refer to Section III, C "Organizational Structure".

D. Annual Report Data
This requirement is fulfilled by the completion of the online narrative and forms; please refer to those sections.